CONFRONTATION

LITERARY MAGAZINE

HUDSON, USA – 2018

ISSUE 123, AUT - III, 2018

LONG ISLAND UNIVERSITY

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

CONFRONTATION – LITERARY JOURNAL

LIU Hudson

Arts & Humanities Citation Index via WEB OF SCIENCE

Our History

Confrontation Magazine began operation in 1968 with the mission of bringing new talent to light in the shadows cast by well-known authors. Open to all submissions, each issue contains original work by famous and by lesser-known writers.

Among the authors we've published are Nobel prize winners John Steinbeck, Derek Walcott, Isaac Bashevis Singer, Joseph Brodsky, Nadine Gordimer, S.Y. Agnon; and Pulitzer and other prize winners W.H. Auden, Arthur Miller, Ned Rorem, Ed Bullins, Joyce Carol Oates, T.C. Boyle, and Lanford Wilson.

The magazine has also published the work of a 14-year-old talented writer, college students and writers beginning their career. Cynthia Ozick, Paul Theroux, Walter Abish, and Susan Vreeland all published work in the magazine before they achieved wider fame. Confrontation is eclectic; eclecticism is in fact our mission.

Masthead:

Confrontation remains indebted to the generosity of Mrs. Carleton Palmer, without whose legacy no issue of this journal would be possible.

AIMS and SCOPE

Websites: www.confrontationjournal.org
Email: info@confrontationjournal.org
Indexed by Thomson Reuters Emerginch Citation & Scopus & GOOGLE Scholar

720 Northern Boulevard, Brookville, NY 11548
LIU Brooklyn
1 University Plaza (corner of Flatbush and DeKalb Avenues)
Brooklyn, NY 11201
General Phone: 718-488-1000
Admissions Phone: 718-488-1011
Admissions Inquiries: bkln-admissions@liu.edu

CONTENTS

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Article

Poetry Movement and the settler nationalism

Dan Tout

Uk, Long Island Univ. Department of Cultural Studies
Dan.tout00@hotmail.com

Abstract

Each of these movements, in one way or another responded to the problems of settler colonialism and modernity in ways informed by their own cultural and political histories and circumstances. While a comprehensive account of the diversity of these movements falls outside the scope of the current discussion, in each instance they involved a turn towards what Ingamells would call 'environmental values', as well as—in a spirit of appropriation yet with sometimes positive long-range outcomes for the subjects of said appropriation—local indigenous peoples, in a varied set of attempts to overcome the exigencies of the settler-colonial situation. The broader tradition identified here thus reaches beyond the Jindies' rather more limited historical and geographical confines. One of the virtues of a settler colonial studies interpretive perspective is its ability to identify and account for 'the continuities, discontinuities, adjustments, and departures' within and between settler societies, and against non-settler ones as well (Wolfe, 'Elimination' 402). This is work that, with respect to the Jindies, remains to be undertaken elsewhere. The sketch is an indictment of the sensibilities of the medical profession. A few years before Rowlandson's sketch, William Nolan's *An Essay on Humanity; or, A View of Abuses in Hospitals* castigated nurses and doctors for their lack of 'sensibility' and 'compassionate attention'. He accused them of practising 'cruelty' and scolded surgeons for being too eager to amputate infected limbs, without considering the alternatives. 'Surely', Nolan argued, 'in a matter of such magnitude to human nature', surgeons should pause before wielding their knivesTranslating pain into tangible images brings it into the public consciousness, raising the spectre of bodily suffering as virtually intrinsic to the human condition. Beginning with Descartes, who famously advanced mind-body theories in the late seventeenth century, this

essay explores the effects of his influence together with shifting attitudes towards pain and its role over the long nineteenth century.

Keywords: formulating, nationalism, indigension, insensible.

In formulating their program in these terms, the Jindyworobaks conformed to a broader tradition. David Carter has referred to its 'radical originality': seeking to identify Australia's genius loci, the spirit of this place, as a source of alterity and to solve the problems of settler nationalism by means of an originary emergence. Yet as this essay argues, this tradition is itself characteristic of the 'multifaceted ambivalence' of settler-colonial nationalism (Thomas 34). Indeed, conflicts and misconceptions such as those surrounding the Jindyworobaks are typical of settler societies, in which the tensions produced by a system of relations involving settler, metropolitan and indigenous agencies mean that the imperatives towards settler indigenisation and neo-European replication compete for supremacy but are never ultimately resolved (Veracini chapter one). The concluding sections of this paper therefore introduce a settler colonial studies interpretive perspective in order to propose an original interpretation of the Jindyworobaks as neither universalist nor exclusively nationalist, and neither nationalist nor exclusively indigenist, but rather ambivalent settler nationalists expressing the typical settler-colonial desire to overcome the contingencies characteristic of the settler-colonial condition.

There is an important thread in the historiography on Ingamells and the Jindyworobaks that identifies, but cannot specify, the imperatives underlying their approach as deriving from Australia's settler-colonial conditions.[1] Yet this thread does not elaborate the implications of such an interpretation. Importantly, the reinterpretation proposed here is not delimited by either history or geography, yet takes both factors seriously. Indeed, while Les Murray has described himself proudly, if half in jest, as the 'Last of the Jindyworobaks' (Elliott, 'Editor's Note' 283), the cultural dynamics of settler colonialism this essay identifies and applies to Ingamells and the Jindyworobaks extend well beyond this admittedly limited historical example. Paul Keating's recent call for the 'blending of black and white Australia to create [a] new national identity' stands as only the most recent and public example of a persistent concern for settler indigenisation (Taylor), or what Philip Mead has described as 'a continuing desire in the white Australian imaginary … for a species of cultural-racial syncretism' (560).

Perhaps even more significantly still, the imperatives and exigencies identified

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

here are no more limited by geography than they are by chronology: similar movements driven by similar concerns, albeit exhibiting distinctive characteristics on the basis of differing cultural and political contexts, can be identified in, for example, the literary-cultural strands of Andean indigenismo in Latin America (Coronado; Rama), l'École d'Alger (Dunwoodie; Haddour), the Ca-

in 1944 on the grounds that she was undertaking

A study of Australian literary-historical movements, at one point finding analogous 'moments' in the literary history of another southern continent in the New

suffering, imaginable by other people. Pain that is often tucked away in some private, grey-tinged, shadowy space is abruptly allowed to flow into public consciousness, a well of red anguish. In this public sphere, the struggle that many sufferers face — that of distinguishing bodily from mental distress — is particularly acute. Famously, in the seventeenth century, René Descartes drew a distinction between the mind and the body this dichotomy dominated thinking throughout the nineteenth century. But, as people-in-pain have often discovered, embodiment is not a mechanistic process as Descartes would have it. The inextricable coupling of mind and body is eloquently observed in Virginia Woolf's On Being Ill (1930). 'All day, all night', she writes, the body intervenes; blunts or sharpens, colours or discolours, turns to wax in the warmth of June, hardens to tallow in the murk of February. The creatures within can only gaze through the pane — smudged or rosy; it cannot separate off from the body

naanites in Israel (Ohana; Piterberg chapter three), and the Maorilanders in New Zealand (Stafford and Williams). Ever-sensitive and insightful, Nettie Palmer was awake to the comparative dimension at the time the Jindyworobaks were writing, requesting a statement of 'Jindy theory' from Ingamells

World: Latin-America. Only its Jindies try to go to a period of the Incas, the Incas whose records and race were blotted out by the Spanish conquest. (Palmer). The act of translating pain into images converts unique, isolated misery into tangible like the sheath of a knife or the pod of a pea.1

That inner creature who gazes out is a sociable 'self'. Anxiety and terror can encourage the development of communities of sympathy. The person-in-pain seeks succour [Fig. 2]. When overwhelmed with pain as a child, for instance, Harriet Martineau's mother and father would 'tenderly' call for her to come to them, and she would rest her head on her mother's 'warm bosom [...] and [wish] that I need never move again'.2 But visions of physical pain can also arouse cruelty. People-in-pain might be accused of fabricating their own rack upon which to writhe [Fig. 2 and Fig. 4]. Physicians and other care-givers might be impervious to the sufferers' cries [Fig. 3, Fig. 4, and Fig. 5]. 'Imperturbability' is an 'essential bodily virtue' for physicians, Sir William Osler famously declared in 1904, but might it be an ambiguous blessing for patients?3 Anaesthetics and effective analgesics silence the person-in-pain [Fig.

6and Fig. 7]. Pain, once again, retreats to private, silent depths.

The most influential model of pain is the mechanistic one espoused by philosopher René Descartes. In 'Meditations on First Philosophy' (1641), Descartes insisted that 'I have a body which is adversely affected when I feel pain'. He went on to say that

Nature teaches me by these sensations of pain [...] that I am not only lodged in my body as a pilot in a vessel, but that I am very closely united to it, and so to speak so intermingled with it that I seem to compose with it one whole.4

Despite Descartes' attempts to show how body and mind 'intermingled', he became known for the Cartesian distinction between body and mind, arising largely from his famous image of the mechanism of pain, which was published in Traité de l'homme, fourteen years after his death.5 In this image [Fig. 1], fast-moving particles of fire rush up a nerve fibre from the foot towards the brain, activating animal spirits which then travel back down the nerves, causing the foot to move away from the flame. According to this model, the body was a mechanism that worked 'just as, pulling on one end of a cord, one simultaneously rings a bell which hangs at the opposite end'.6

It was a profoundly influential theory, especially after it became the model of the body propagated by the founder of clinical teaching, Herman Boerhaave. Despite the fact that it has subsequently been dismantled, Descartes' way of conceiving of pain remained remarkably intact throughout the nineteenth and twentieth centuries. Descartes' filaments and animal spirit were converted into nociceptive impulses and endorphins, but his mechanistic metaphor and the Cartesian distinction between bodily pain and psychological suffering remained in place until Ronald Melzack and Richard Wall invented the Gate Control Theory of Pain in 1965.7 Their model showed how perceptions of pain were modulated by complex feedback systems. Context, including psychological cues, became central to the understanding of pain.

It is often said that the experience of pain isolates sufferers. But pain can also create bonds of sociability. This statue of a man suffering the agonies of gout in his big toe was produced in the late eighteenth century by the distinguished German porcelain company, Meissen [Fig. 2]. Gout typically caused agonizing pain in the big toes and other joints. According to the cleric and writer Rev. Sydney Smith, it was 'like walking on my eyeballs'.8 In this figurine the sufferer is surrounded by symbols of the cause of his affliction, that is, alcohol, rich foods, and other evidence of profligate living. Sufferers are responsible for their affliction. His son is shown sitting in a miniature chair with his foot slightly raised, indicating the hereditary nature of the disease. The gout sufferer is receiving succour from his wife. Representations of both the disease and the person providing sympathy are highly gendered. The image of the gout

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

sufferer is almost without exception that of a middle-aged or elderly man, while the person responding with sympathy to the person-in-pain is typically a sexually attractive, young woman.

Thomas Rowlandson sketched 'Amputation' in 1793, over fifty years before the invention of effective anaesthetics such as ether or chloroform [Fig. 3]. It shows a man tied to a chair, having his right leg amputated. He is screaming in agony. The main surgeon is wearing a carpenter's apron and is conducting the amputation with a common saw. An assistant holds a wooden crutch. The amputation is taking place in a dissecting room (a corpse can be seen in the lower right-hand corner) and on the walls are articulated skeletons, alluding to panics about resurrectionists (that is, men who 'resurrected' corpses from graveyards in order to sell them to dissecting schools for use in training medical students). The bewigged and bespectacled doctors are impervious to the man's agony. On the wall is a list of surgeons, including Sir Valiant Venery, Dr Peter Putrid, Launcelot Slashmuscle, Cristopher Cutgutt, and Benjamin Bowels.

. This was particularly the case given 'the horrible fears that anticipation [of amputation] unavoidably excites in the patient's mind' and the 'excruciating pain' of the actual operation.9 As another critic put it in the 1850s, some physicians had acquired a 'taste for screams and groans' and were unable to 'proceed agreeably in their operations without such a musical accompaniment'.10 When effective anaesthetics were eventually introduced, many physicians argued against their use on the grounds that the tortuous pains of surgical operations were necessary to prevent haemorrhage. As the vice-president of the American Medical Association pronounced in 1849, pain was 'curative [...]. The actions of life are maintained by it.' Without 'the stimulation induced by pain', surgery would 'more frequently be followed by dissolution'.11

Eighteenth- and early nineteenth-century medicine was patient-orientated, with sufferers of pain and illness as likely to have recourse to 'quacks' as to regular physicians. Indeed, the distinction between the two kinds of practitioners was not as great as it was to become later in the nineteenth century, with the introduction of state regulation and the professionalization of medicine.

James Gillray's 1801 satire on 'Metallic Tractors' or Samuel Perkins's needles was an attempt to discredit 'quacks' [Fig. 4]. Metallic Tractors were two needles — one made of brass and the other of iron — with which practitioners would stroke painful afflictions as varied as rheumatism, gout, inflammation in the eyes, erysipelas, epileptic fits, locked jaw, burns, and all kinds of 'pains in the head, teeth, ears, breast, side, back, and limbs'.12 The pain of gout, Benjamin Douglas Perkins (the son of Samuel Perkins and the person who patented the Tractors in the United Kingdom) explained, was caused by a 'want of perspiration' in the toe which made it become 'positively electrified' while the 'other perspiring parts of the body [were] negatively electrified'. The pain would disappear

if the 'equilibrium of electricity' could be restored 'by means of the distribution of the negative electricity in the body to the positive'. A healthy physician who was 'negatively electrified' should hold the Metallic Tractor against the painful toe, effectively communicating his negative electricity to the inflamed toe.13 Tractors were sold in the UK for five guineas, or the annual salary of a female servant.

Gillroy's sketch pits an arrogant, charlatan physician against a 'True Briton' who has been over-indulging in alcohol. On the wall hangs a painting of Dionysus, riding on a West Indian rum barrel, and, on the table, punch made of brandy, tea, sugar, and lemons is brewing. The patient is experiencing extreme pain: his hands are clenched, his teeth are grinding, and his wig is falling from his scalp. His dog howls in sympathy.

'Metallic Tractors' were exposed as a fraud by Dr John Haygarth in Of the Imagination, as a Cause and as a Cure of Disorders of the Body (1800).14 Defenders of the Perkinean Institute, however, claimed to be able to prove the efficacy of the needle. One defender of metallic tractors claimed to have cured a labouring man from Etton (Yorkshire) of 'violent Rheumatism in his right arm'. Afterwards, when the patient was asked his opinion of the operation, he replied that he thought it was 'very silly'. This response convinced the defender of the tractors that the cure had not been due to 'the imagination, but the Metallic Tractors'.15

Emile-Edouard Mouchy's oil painting of 1832 shows a 'physiological demonstration' of a dog inside a garret [Fig. 5]. The dog is tied to the table, which has been specially fitted with metal rings. The dog is clearly howling in pain but the overall arrangement of the painting is of scientific objectivity and manly rationality. Indeed, the painting was intended to valorize physiological experiments as central to scientific progress. There has been some speculation that the surgeon is François Magendie, the foremost French experimental physiologist who, in the 1830s, would start his lecture series by opening the abdomen of a dog.

Do dogs like the ones in this painting truly feel pain? For vivisectors, the answer was simple: animals were close enough to humans to make such experiments worthwhile but not so close to make vivisecting them cruel. According to Descartes, animals were mere 'automa' or moving machines, driven by instinct alone. He believed that animals' screams of pain were simply mechanical responses, which functioned as a form of human moral edification.16 More commonly, scientists and philosophers of the early nineteenth century pointed to the existence of a hierarchy of sentience. After all, they insisted, isn't it the case that not all humans are equally sensitive? The ability to feel, both in terms of physical sensation as well as inner sensibilities, was ranked hierarchically. The regulation of vivisection — because it involved cruelty towards animals, but also on the grounds that allowing cruelty to animals would open the door to

cruelty towards people — occurred earlier in the UK than in the rest of Europe. Indeed, British physiologists such as Sir Charles Bell were much more likely to emphasize dissection as opposed to the French tradition of vivisection.

This is the first daguerreotype of a real operation [Fig. 6]. It was created on 3 April 1847 in the amphitheatre of the Massachusetts General Hospital, where ether had been first used publically as an anaesthetic, six months earlier. It was taken by the famous daguerreotype studio of Albert Southworth and Josiah Hawes, in part as a way of memorializing the pain-shattering achievements of the hospital. The patient — whose head is turned towards anaesthetist Dr Charles Heywood, who holds an ether-soaked sponge — is Athalana Golderman, a young seamstress, who had unintentionally stabbed herself in the leg with her scissors. At the foot of the operating table, on the right-hand side, is John Collins Warren, the surgeon who had performed the first public operation employing William Morton's ether. Opposite him is his son, Jonathan Mason Warren, who had introduced the use of the sponge to administer ether. To the left and rear of the photograph there is a human skeleton and on the right the base and lower limbs of the Apollo Belvedere, a statue of the Greek god associated with healing. The operation is being watched by students and visiting physicians who sit in a semicircle of benches that rise up steeply along the sides of the amphitheatre.

The introduction of anaesthetics was widely regarded to have promoted a certain kind of detachment, and certainly the staged feel of this daguerreotype effectively catches this new, surgical comportment. The impact of anaesthetics on operatives was alluded to by James Miller in Surgical Experience of Chloroform (1848) when he noted that, in the days before anaesthetics, medical students and surgeons 'grew pale and sickened, and even fell, in witnessing operations' — not because of the 'mere sight of blood, or of wound' but 'from the manifestation of pain and agony emitted by the patient'. In contrast, he continued, after the invention of anaesthetics these medical practitioners were spared the need to emotionally engage (or, indeed, attempt to disengage) with patients since 'a snort is the worst sound' they made.17 In the words of a physician writing in 1863, surgery became 'slow dissection', a term generally used about corpses, not living patients.18 David Cheever bluntly expressed it in 'What has Anæsthetics Done for Surgery?' (1897): as a result of anaesthetics, he observed, the surgeon 'need not hurry; he need not sympathize; he need not worry; he can calmly dissect, as on a dead body'.19

This watercolour by Richard Tennant Cooper was commissioned in 1912 by Henry S. Wellcome, the founder of the influential charity, the Wellcome Trust [Fig. 7]. It suggests some of the more disturbing aspects of chloroform. While the body is rendered insensible, it is toyed with by demons and bat-like spirits. Anaesthetics transport the patient into a state without physical pain, but they also unleash worlds of unconscious, hostile drives. They render the person passive. The painting also por-

trays anxieties about the comatose body, placed at the mercy of outside agents, including surgeons. This was one reason for the hostility to anaesthetics when they were first introduced. Critics observed the immense power that anaesthetics gave surgeons over patients: patients could be treated as 'things', with no rights over their own body. In the words of physician James Arnold in The Question Considered; Is It Justifiable to Administer Chloroform in Surgical Operations (1854), the 'apoplectic stupor produced by chloroform' placed the patient at 'risk of delirious expression of thought' — that is, they might utter impious oaths rather than invoke verses proclaiming their closeness to the suffering Christ. Arnold regarded this as a problem, 'as respects woman particularly'. If women were made aware of this risk in using chloroform, it would 'deter them from its unnecessary use' (Arnold, pp. 16, 24). Chloroform disrupted coherent, godly pain-narratives. The insensible body was vulnerable to all manner of abuses.

References

1. Ahluwalia, Pal. 'When Does a Settler Become a Native? Citizenship and Identity in a Settler Society.' Pretexts: Literary and Cultural Studies 10.1 (2001): 63-73.

2.Ashcroft, Bill, Gareth Griffiths and Helen Tiffin. The Empire Writes Back: Theory and Practice in Post-Colonial Literatures. 1989. 2nd ed. London: Routledge, 2002.

3. Bird, David S. Nazi Dreamtime: Australian Enthusiasts for Hitler's Germany. North Melbourne: Australian Scholarly Publishing, 2012.

4. René Descartes, 'Meditations on First Philosophy', in *Descartes: Key Philosophical Writings*, trans. by Elizabeth S. Haldane and G. R. T. Ross, ed. by Enrique Chávez-Arvizo (Ware: Wordsworth Editions, 1997), pp. 123–90, (p. 183).

5. René Descartes, *Traité de l'homme* (Paris: Clerselier, 1664), p. 27.

6. Descartes, 'Meditations', p. 183; and *Traité de l'homme*, p. 27.

7. Ronald Melzack and Richard Wall, 'Pain Mechanisms: A New Theory', *Science,* 150 (1965), 971–79.

8.Lady Holland, *A Memoir of the Rev. Sydney Smith,* 2 vols (London: Longman, Brown, Green, and Longmans, 1855), I, 3.

9. William Nolan, *An Essay on Humanity; or, A View of Abuses in Hospitals*(London: the Author, 1786), pp. 24–25, 37–38.

10. James Arnold, *The Question Considered; Is It Justifiable to Administer Chloroform in Surgical Operations* (London: Churchill, 1854), p. 3. He was alluding to the vivisector Professor Magendie.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

11. J. P. Harrison, 'On the Physiology, Pathology, and Therapeutics of Pain', *Western Lancet,* 9 (1849), 349–54.

12. Charles Cunningham Langworthy, *A View of the Perkinean Electricity; or, An Essay into the Influence of Metallic Tractors* (Bath: the Author, 1798), p. 37.

13. Benjamin Douglas Perkins, *The Influence of Metallic Tractors on the Human Body* (London: the Author, 1798), p. 23.

14.Dr John Haygarth, *Of the Imagination, as a Cause and as a Cure of Disorders of the Body* (Bath: the Author, 1801).

15. Henry Grimston, *An Apology for Believing in the Metallic Tractors, with Some Account of the Perkinean Institute* (London: Hatchard, 1803), pp. 6–7.

16.René Descartes, *Discourse on Method and Other Writings*, ed. by F. E. Sutcliffe (Harmondsworth: Penguin, 1968), pp. 73–76.

17. James Miller, *Surgical Experience of Chloroform* (Edinburgh: Sutherland and Knox, 1848), p. 29.

18.Valentine Mott, *Pain and Anæsthetics: An Essay, Introductory to a Series of Surgical and Medical Monographs* (Washington: Government Printing Office, 1863), p. 11.

19. David W. Cheever, 'What has Anaesthesia Done for Surgery?', in *The Semi-Centennial of Anæsthesia* (Boston: Massachusetts General Hospital, 1897), pp. 41–48 (p. 42).

Article

Jindyworobaks and the problems of settler-colonial modernity

By: Birns Nicholas, R.

Department Historical Studies of Governmental Nationalism, Univ.London, Uk

nircholas.bb@london.gov.edu.uk

Abstract

While the concerns of those objecting to the appropriative nature of Jindyworobak indigenism should be taken seriously and are accepted here, such objections also tend to overlook what Goldie has termed the 'impossible necessity' of settler indigenisation (Fear and Temptation 13). As Goldie's account suggests, and Healy's makes clear, sooner or later, one way or another, all those invested in the construction of an 'indigenous' settler national culture find themselves confronting and responding to the figure of the actual, authentic and authoritative, indigene. Since the dual indigenising strategies of disavowal and appropriation similarly enact the further incursion of settler-colonial authority into Aboriginal discursive space, Ingamells' articulation of the Jindyworobak program represents only one, original and exemplary, response to the exigencies of the settler-colonial condition. The alternatives are no less violent in their implications, symbolically or otherwise. This essay reconstructs the controversy over vivisection in the last quarter of the nineteenth century as a history of the emotions to explore how reflexive emotional pain — compassion or sympathy — was idealized, contested, and applied. It deals in part with physiologists' reflections on emotional conditioning as preparation for the aesthetics of the opened body. It also deals with the change in those preparations wrought by the knowledge and application of anaesthetics.This essay explores the interplay of different species of compassion with regard to physiological practices in the final decades of the nineteenth century. Drawing on the lexicon from which ideals of late-Victorian compassion were formed, it illustrates their contested nature, demonstrating how physiologists developed their own concepts of compassion based on the theories of Darwin and Spencer. Within this purview, the essay examines the historical

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

specificity of antivivisectionist compassion as well as ways in which pain in the laboratory was conceptualized, experienced, and managed ethically.

Keywords: Indigenising, colonial condition, symbolically.

The indigenist aspect of the Jindyworobak program and the imperative behind it also complicates the various attempts to classify them as either antimodernist provincial isolationists or, conversely, modernist primitivists. The traditions remain distinct, since the imperatives underlying the settler-colonial compulsion towards indigenism are not commensurate or reducible to those underlying the metropolitan modernist turn towards primitivism. Whereas the latter seeks to recuperate an already superseded and generic state of being as a means of overcoming or escaping a modern malaise conceived in universal (read European) terms, the former seeks to appropriate aspects of a particular and emplaced alterity for the purposes of attaining an always and already desired futurity within a specific locale, the very conditions of which compel their supersession. As Nicholas Thomas remarks:

Primitivism in settler culture is … something both more and less than primitivism in modernist art … Settler primitivism is not … necessarily the project of radical formal innovation stimulated by tribal art that we are familiar with from twentieth-century modernism. It was, rather, often an effort to affirm a local relationship, not with a generic primitive culture, but a particular one. Reflections on the feelings aroused by the sight and by the idea of the surgically opened, living body command the attention of the historian of emotions. The article explores the ways in which the *sight* of suffering — the aesthetics of pain — were mitigated, justified, rationalized, and subjected to emotional control. It argues that a diminution of the aesthetic response to the sight of blood, in conjunction with knowledge of anaesthesia, allowed physiologists to conform to a moral code that abstracted compassion to suffering on a wide scale, removed from the immediacy of the laboratory, and in the name of 'humanity'. This in turn was connected to a newly developed notion of compassion or sympathy at the level of the whole community, of the whole species, or even of all sentient life, that had emerged from the moral philosophy of the theory of evolution. In this context, physiologists' reflections on their emotional equanimity in the laboratory can be connected to the operating callousness of the physician, and both are located in a secular, Darwinian context of the evolution of the emotions. This stands in contrast with antivivisectionist charges of callousness and their own aesthetics of compassion — their own emotional pain — that endured the rise of anaesthetics in physiological experiments.I

Historians have found late nineteenth-century physiologists' equanimity difficult to imagine in practice. Patrizia Guarnieri has opined that 'the activity of the vivisectionist did not necessarily preclude a caring attitude towards animals, or a reciprocal relationship of good-will', but the two things were nevertheless incompatible:

On the one hand, the white-collared scientist who tied down an etherised dog on the operating table who [...] opened its skull and removed the cranial lobes. On the other, the gentleman who always had some delicacy in his pockets for the animals, and made sure that they lacked neither food nor affection. A sort of Dr Jekyll and Mr Hyde perhaps.2

She is not the only one to have drawn such a conclusion. Stewart Richards critiqued the physiologists of the 1870s and 1880s thus:

Whatever their ethical imperatives as private citizens (when they were evidently no less humane than other men), they were able as professional scientists, temporarily but repeatedly, to suspend 'normal' sensibilities in a way that we may recognize as more widely familiar throughout history than the singular case of Dr Jekyll and Mr. Hyde.

He went on to wonder whether John Burdon-Sanderson, about whom more below, had fallen, 'like Dr. Moreau [...] under the spell of research', which was the 'source of a psychological commitment to specific instrumental norms that overwhelmed or obscured any more broadly based ethical misgivings'.3 Paul White has similarly pointed to a process whereby practitioners underwent a 'reversion' in the laboratory, wherein 'bestial instincts were unleashed through the repeated and prolonged infliction of pain on helpless creatures'. This destabilized the 'boundaries between the animal and the human' in the name of clarifying them. Physiologists represented a 'divided self', 'struggling [...] to overcome instinctual sympathies for other creatures in order to fulfill commitments to a higher good'.4

With regard to the latter struggle, White is correct, but I want to develop that argument in terms of the history of sympathy itself. Indeed, I want to explore an idea that White himself has suggested with regard to vivisection, but which is as yet undeveloped: the 'crux of the late-Victorian debates was not just whether particular feelings were present in the experimenter or the animal, but the nature of emotion itself; its role in science and medicine — and in human society generally — seemed open to question'.5 Testing the historiographical credence given to the hardened heart of the late-Victorian scientist requires an investigation into what physiologists thought about causing (or avoiding causing) pain in animals.6 It is necessary to ask what changed after the use of anaesthetics became widespread — whether it matters that the vivisected dog in Guarnieri's imagined scene was 'etherised'. If one chooses not to set out to find Edward Hyde or Dr Moreau, one may encounter instead a complex

individual who managed a logical consistency in his ethics and practice, and who did not exemplify a Victorian caricature of personality disorder. If we wish to leave literary fantasies behind, we need to inquire anew about the ways in which pain in the laboratory was conceptualized, reflexively experienced, and ethically handled.7

The controversy over vivisection that began with the publication of the *Handbook for the Physiological Laboratory* in 1873, in the context of a prolific development of physiological specialism imported from Continental Europe, has a well-established historical narrative.8Public attention was focussed by a Royal Commission on the Practice of Subjecting Live Animals to Experiments for Scientific Purposes, followed by the Cruelty to Animals Act of 1876, by which animal experimentation became subject to a government licensing system. The public inquiry of the mid-1870s encompassed the following questions: the utility of experimental research; the 'humanity' of physiologists at home and abroad; and the degree to which animals could, or should, suffer pain. In general within medical science, there was little dissension with regard to the benefits already derived, and the wealth of humanitarian relief to follow, from physiological research. The difficulty lay in the moral price at which those benefits were purchased. The Royal Commission proceeded to assess this difficulty, paying considerable attention to the moral consequences of animal pain and the use of anaesthetics. I will deal with these two things in turn.

To what extent were experimental animals thought to feel pain? Where did that pain weigh in the balance of comparative suffering? The answers to these questions allowed medical scientists to rationalize their own feelings in response to the experience of (inflicting) animal pain. G. M. Humphrey, Professor of Anatomy at the University of Cambridge, told the Royal Commission that the comparative smallness of animal nervous systems indicated that they could not possibly suffer so acutely as humans. Moreover, signs of a struggle were not construed as reliable indicators of pain. The 'violent contortions of the worm' on a hook did not necessarily indicate pain, 'for there may be violent contortions and no suffering whatever'. So much, Humphrey said, had been learnt from the painless muscular excitations of men under chloroform, which looked like pain but were not, as well as from the painless convulsions of epileptics.9

This commonly stated opinion captured physiologists' distrust of the outward signs of pain, which might otherwise have led to unwanted or inappropriate emotional responses to it.10 Such reactions were deemed part of a culture of sentimentalism against which physiology aligned itself. It was exemplified by the secretary of the Royal Society for the Prevention of Cruelty to Animals, John Colam, who told the Royal Commission of his attendance at a lecture in the Spring of 1875 at the London Institution, given by Sir David Ferrier. It was probably a version of Ferrier's Croonian Lecture, given in May of that year, on 'Experiments on the Brain of

Monkeys'.11 Ferrier described in great detail his methods of removing parts of the brains of various monkeys, and his observations of their altered states thereafter. The audience, which was comprised of the general public, including 'several young people' and 'several young ladies too', laughed throughout at Ferrier's descriptions of the monkeys' grotesque movements and facial contortions. Colam thought the lecture 'was a long way out of good taste', and was 'sensational'. He was not alluding to the aesthetic qualities of monkeys, who were 'incapable of suffering' during the operations, but rather to it being 'a case of levity, likely to produce a bad effect'. These important investigations were objectionable because they were pitched at the level of 'what is called popular'. There was, Colam thought, 'scarcely that decorum which you would expect [...] in a man who was describing the condition of animals which had been mutilated by himself'. The grotesque nature of the subject, coupled with the audience's response to it, caused Colam and his companions pain. Indeed, one of his accompanying gentlemen 'left the room in consequence of the pain with which he saw the laughter of the young people' (Royal Commission on Vivisection, pp. 82–83).

Physiologists believed that the lack of pain in the animal removed any objections on the grounds of taste, and saw the emotional pain of antivivisectionists under such conditions as nothing more than a sentimental (feminine) reaction. James Crichton-Browne, the eminent alienist, had defended Ferrier, with whom he worked at the West Riding Asylum, in precisely these terms. The outward signs of pain could be achieved in animals without a brain, 'or in the deepest state of anaesthesia' by a simple 'stimulation of the motor centre'. The apparent 'intense and protracted agony' was 'not greater than that of a pianoforte when its keys are struck'.12

According to George Burrows, who was President of the Royal College of Physicians, only a 'very limited number of experiments [...] will cause a degree of pain to the animal', and under those circumstances it would be 'painful to the operator and to everybody else to contemplate'.13 Compassion in the immediate setting of the laboratory was therefore rationally limited. The pathologist James Paget, trusting in the 'general humanity of scientific men', thought they could be 'left to be fair judges' of the 'amount of pain it is reasonable to inflict for the sake of attaining some useful knowledge'.14 The common concern that vivisection tended to brutalize the operator could be dismissed on the basis that animals' exposure to pain was minimized, for some of them by their lowly nervous systems, and for others by the use of anaesthetics. The anatomist William Sharpey was convinced that experimentation did not have 'the effect of blunting the feelings' or 'hardening the nature' of physiologists, but most agreed that this had to do with the superior qualities of the men involved.15 As Darwin's principal disciple George Romanes, who was himself a prac-

tising physiologist, later pointed out, 'our physiologists as a class are not less English gentlemen because they are highly cultured men of science'.16

Even after the use of anaesthetics was prevalent, comparative capacities of sensitivity to pain were continually used to justify experimentation, perhaps because anaesthesia was not deemed appropriate for every experiment.17 'The sole means', according to the psychologist Edmund Gurney, of arriving at a 'conscientious estimate of others' suffering [...] lie in imagining it as one's own'. The anthropomorphism of this cross-species compassion raised the suspicion that animals were commonly allocated a greater capacity for experiencing pain than their physiologies warranted. Gurney argued for a 'close relation of suffering to intelligence'.18 Intellect was the key factor that enhanced suffering, and humans — even to the ardent utilitarian — were thought to have the largest share. Some animals shared the physiological systems of humans, but their brains were 'in proportion to the rest of the body, very much smaller than in the case of man' (Collier, p. 624). Given the likely benefits derived from physiology, vivisection could thus be justified.

These utilitarians had a good precedent for proceeding in this manner, for J. S. Mill had long since said that a 'being of higher faculties requires more to make him happy, is capable probably of more acute suffering, and certainly accessible to it at more points, than one of an inferior type'. It was, after all, worse to be a human being in pain than a pig in pain; worse to be Socrates in pain than a fool in pain.19 The twist was to say, with one eye on the anti-vivisection movement, that if anybody thought differently about the pig or the fool on behalf of the pig or the fool, they were guilty of a category error, for in fact these advocates only knew their own side of the equation.

At the International Medical Congress (IMC) held in London in 1881, John Simon gave a widely heralded speech defending medical science. He particularly denounced the aesthetic sensibilities of anti-vivisectionists: 'In certain circles of society', he said, 'aesthetics count for all in all; and an emotion against what they are pleased to call "vivisection" answers their purpose of the moment as well as any other little emotion.' The medical profession could not seriously argue with such people, for they did not share a moral standard, or a world view:

We have to think of usefulness to man. And to us, according to our standard of right and wrong, perhaps those lackadaisical aesthetics may seem but a feeble form of sensuality.

But that was not to say that he felt nothing with regard to his work. On the contrary, he thought of inflicting pain 'with true compunction', but he did it nonetheless because of the 'end which it subserves': the promotion of 'the cure or prevention of disease in the race to which the animal belongs, or in the animal kingdom generally, or (above all) in the race of man'. Under such conditions he would not 'flinch' from this 'professional duty, though a painful

one'. Simon was referring to his own pain.20

British medical scientists in the 1870s and 1880s were therefore acutely aware of the reflexive problems of causing pain. At worst, it might adversely affect their own 'nerve', and prevent them from following through their inquiries to the fullest extent. The infliction of pain on an animal, where unnecessary, might betray a callousness that could affect society at large. Physiologists generally concluded that vivisection without anaesthetic was difficult because animal suffering was, however mitigated, real. But, all things considered, it was worth it, nonetheless.

III

Physiologists thought that concerns about causing pain should have been put to rest by the widespread use of anaesthetics, which were employed in the vast majority of experiments. The primary benefit of anaesthetics was not that the experimental animal no longer suffered, but that the major concerns of the physiologist were alleviated: the greater good could be sought unhindered, the operator would not lose his nerve, and he would safeguard his 'feeling' heart. On a practical level, it also meant that the animal would keep still, though this fact was seldom mentioned.21 Anaesthesia objectified the experimental subject, allowing physiologists methodically to remove emotions, not *from* themselves, but *to* more distant, abstract objects. Without anaesthetic, the experimental animal's status as a sensitive being could involve it in a reciprocity of aesthesia, of physical pain in the animal and the reflection of that pain — compassion — in the operator. This might inhibit the researcher in beginning, or in pursuing the ultimate ends of his research. As Carolyn Burdett has recently argued:

Aesthetic response belongs in the relation between viewer and object, as a consequence of what the object precipitates or excites in the body of the viewer. What the viewer then experiences (the consequent feelings or emotions), they then project back and experience anew, as if located in the object.22

Indeed, not to feel this sympathetic pain might be a sign of brutality, giving rise to the 'general accusation of hardness' to which medical science was accustomed.23 Chloroform and ether were safe ways to cut this reciprocal aesthesia, replacing it with a similar but opposite reciprocity of *an*aesthesia that could preserve both the nerve and the tenderness of the operator.24 The benumbed object excited nothing in the viewer (operator), eliminating the possibility of projecting sensation back into the object. As such, William Carpenter averred that 'removing' pain had become a 'matter of duty' for physiologists, who could project their sympathetic gaze outside of the laboratory (Royal Commission on Vivisection, p. 282). By rendering the experimental subject as object, emotions were removed from the physiological procedure, in the name of a more abstract 'humanity'.25

There is a wealth of evidence to demonstrate that physiologists knew that they were doing exactly this, even though they may have thought it possible without anaesthetics.26 John Burdon-Sanderson, co-author and editor of the *Handbook for the Physiological Laboratory*(1873), averred his belief in a certain capacity inherent in the highly evolved civilized male. A man, much more so than a woman, was capable of 'directing mental effort to a recognized purpose' without succumbing to the 'greatest enemies', those 'emotional or sentimental states', including sympathy, which so often 'handicapped' women in their endeavours. A scientific man was singularly well equipped for a 'life directed to the fulfilment of a recognized purpose to which others must yield'.27 Burdon-Sanderson famously neglected the subject of anaesthetics in the *Handbook*, and was repeatedly asked to justify the infliction of pain in the physiological laboratory, which he did by reference to 'the circumstance that we are working for an important and good object' (Royal Commission on Vivisection, p. 142). But if the infliction of pain could be justified if there was 'a certainty that the human race would be benefited by it', how much more easily could an experiment be justified under anaesthesia? (Royal Commission on Vivisection, p. 146.) Burdon-Sanderson acknowledged that he 'should condemn the non-employment of anaesthesia' wherever anaesthesia could be used, and indeed acknowledged that he had failed in not making this clear in the *Handbook* (Royal Commission on Vivisection, pp. 115, 119, 126.) Yet he remained convinced that responsibility for ensuring the 'greatest possible result', 'at the expense of as little suffering as possible', lay with the scientist himself (Lady Burdon Sanderson, pp. 101, 103). It might even be argued that the failure of the *Handbook*'s authors to make humanitarian overtures towards those whom Burdon-Sanderson would have adjudged to have succumbed to their 'emotional or sentimental states' was consistent with an imperturbable direction of mental effort. The *Handbook*'s diagrammatical gaze into the bodies of the frog, the rabbit, and the dog was imagined in such a way as to avoid the aesthetic sensibilities associated with the bloody wound. Rather, furry-edged incisions were simply windows, abstracted from the animal body as a whole, displaying veins, arteries, nerves, ganglions, and glands [*Fig. 1*].28

Another of the *Handbook*'s authors,the noted Scottish physician Thomas Lauder Brunton, also expatiated on the special qualities of the scientist, making the distinction between two types of compassion. Both medical scientists and antivivisectionists were 'anxious to lessen the amount of pain and suffering in the world', but where one looked to 'the immediate and designed suffering of a few score of animals', the other looked to 'the ultimate relief of the undesigned pains of disease in animals and in men'. To civilized people, Lauder Brunton admitted, the 'mere sight of suffering is painful'. This 'painful impression' causes some immediately to turn away and thus 'be rid of the disagreeable feeling'. For others, 'it excites a desire to relieve the pain of the sufferer, however

disagreeable, disgusting, or trying the task may be.' He put physiologists in the latter group. Such a 'power of controlling one's own emotions, of disregarding one's own feelings at the sight of suffering' varied from person to person, but it could be trained. It involved subordinating emotion to judgement, and it was aided in the case of physiology by practice, knowledge, and anaesthetics. The daily experience of experiment would, in itself, help with the process of putting judgement before feeling, allowing these 'humane men' to 'purchase future good at the expense of present pain'.29 E. Ray Lankester had made the same point in 1873, pleading that the 'experimenter often suffers most acutely from his sympathy with the animal, but controls his emotion and endures his pain in companionship with the dumb animal for the sake of science'.30 But since the 'great majority' of experiments were 'rendered painless by means of anaesthetic agents', physiologists could, with measured judgement, learn 'to disregard their own feelings, and to concentrate their attention on the interests of the [human] patient' (Lauder Brunton, p. 480).

It was to this measured judgement that the physician and great supporter of vivisection, William Osler, referred in 1889, before a class of new graduates in medicine at the University of Pennsylvania. Osler, whose experience defending vivisection was transatlantic in scope, saw the essential connection between vivisection and surgery, and felt that the qualities of the 'imperturbable' surgeon were kindred with the laboratory physiologist.31 The practitioner was lost if he felt his patient's pain.32 He urged his new young colleagues to have their 'nerves well in hand' and to avoid the slightest facial expression of 'anxiety or fear' even under 'the most serious circumstances'. To fail in this regard betrayed an inability to put one's 'medullary centres under the highest control', and would lead to disaster. 'Imperturbability' was a 'bodily endowment' that ensured 'coolness', 'calmness', and 'clearness of judgment in moments of grave peril'. It was character defined by '*phlegm*':

> Now a certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of a calm judgment, and in carrying out delicate operations. Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.

He urged his young charges to 'cultivate [...] such a judicious measure of obtuseness' that would 'meet the exigencies of practice with firmness and courage, without, at the same time, hardening "the human heart by which we live"'.33

For Osler, physiologists had the additional quality of an 'experimental spirit in medicine', with which there was 'nothing else in human endeavour to compare from the standpoint of humanity'. He agreed

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

with his colleague Harvey Cushing that there was a 'feeling of regret [...] that animals, particularly dogs, should thus be subjected to operations, even though the object be a most desirable one and accomplished without the infliction of pain', but his conclusion was clear: the 'humanity of the physiologists' could be trusted implicitly. This humanity — compassion in the broadest sense — had been adhered to through 'lives of devotion and self-sacrifice', through a useful callousness, and carried to an 'incalculable' extent.34

Osler affirmed this in 1907, but it had been forcefully asserted by the institution of medicine at large as early as 1881. The IMC in London, the largest ever assemblage of eminent medical men from around the world to that date, unanimously passed a resolution that had been drawn up under the auspices of the Physiological Society. It recorded the latter's 'conviction that experiments on living animals have proved of the utmost service to medicine in the past, and are indispensible to its future progress'. It strongly deprecated the infliction of 'unnecessary pain', but demanded 'in the interest of man and of animals' that 'competent persons' should not be restricted in their experiments.35 In addition, many of the age's most prominent medical scientists and physicians came forth with their own similar defences. Gerald Yeo, professor of physiology at King's College London, underscored the profession's abhorrence at the infliction of pain by laying before the public an extended analysis of the prevalence of anaesthetic usage, setting out to prove that there was no 'want of tenderness amongst English physiologists' and that 'Pain forms [...] but a rare incident in the work of a practical physiologist'. William Gull emphasized the 'moral duty' of investigating 'problems of the highest importance to mankind' when the 'solution of these problems is within the scope of the human intellect'. This course by no means made physiologists 'indifferent to or careless of inflicting pain'. Their character had already been safeguarded by the 1871 resolutions of the British Association, the first of which read: 'No experiment which can be performed under the influence of an anaesthetic ought to be done without it.' It was with happiness that he noted that the 'great majority' of experiments on the nervous system 'are performed on decapitated frogs, or on other animals under the influence of anaesthetics'.36

Physiologists, as a body, were pain-aware, mindful of the freedom given to them by anaesthetics and focussed on what they perceived to be the higher moral ends of their operations. Those moral ends, understood as the alleviation of all human suffering, were embedded within the moral theories of Darwin and his contemporaries, who sought to explain the evolution of compassion as the mainspring of moral action. To better appreciate those moral ends, as well as to understand the grounds upon which antivivisection could be rejected, we must turn to the evolutionary ethics that informed physiological practice.

The link between physiology and evolutionary ethics is abundantly clear, and Darwin himself worked behind the scenes in collaboration with John Burdon-

Sanderson, John Simon, T. H. Huxley, and others to ensure protective legislation for physiologists.37 George Romanes, one of Darwin's most ardent supporters, was a principal agitator in the defence of physiology, and even suggested that Darwin write a pro-vivisection article for the monthly literary journal, the *Nineteenth Century*, entitled 'Mistaken Humanity of the Agitation: Real Humanity of Vivisection'. Thomas Huxley served as the most notable defender of vivisection on the committee of the Royal Commission on Vivisection, while elsewhere publicly denouncing 'the venomous sentim[ent]ality & inhuman tenderness of the members of the Society for the infliction of cruelty on Man — who are ready to let disease torture hecatombs of men as long as poodles are happy'. Herbert Spencer is reputed to have regarded vivisection to have been 'so justified by utility to be legitimate, expedient, and right', on the condition of State supervision.38 In their defence of physiology, evolutionary ethicists offered a new interpretation of the meaning and implications of sympathy and compassion.

Robert J. Richards has clearly demonstrated that Darwin's evolutionary ethics was 'a morality of intentions'. This meant judging moral action not on what was done, in abstraction, but on the intended outcome. To better do this, according to Darwin, 'we must look *far forward* & to the *general action* — certainly because it is the result of what has *generally* been best for our good *far back*.'39 The loose body of evolutionary scientists characterized antivivisectionists as adherents to a 'false' or 'mistaken' humanity because they allowed their conduct to be led by an immediate reaction to what they saw, or sensed, as wrong, without due consideration for what was actually good for humanity. Sympathy in an advanced civilization was extended beyond the confines of the family through its connection to the evolution of the intellect. 'The highest possible stage in moral culture', Darwin wrote, 'is when we recognise that we ought to control our thoughts'. Sympathy, by a process of reason, could therefore be extended to all, including animals.40 But that also meant that an immediate sympathetic reaction could be suppressed for the sake of a greater good. The application of Darwin's own moral theory to the matter of vivisection is startlingly clear. In his most famous contribution on the subject Darwin wrote of the

> incalculable benefits which will hereafter be derived from physiology, not only by man, but by the lower animals [...]. In the future every one will be astonished at the ingratitude shown, at least in England, to these benefactors of mankind.41

For Darwin, anaesthetics were morally desirable, but once used there could be no remaining objection to vivisection, a term he wished to replace with 'anaes-section' to clear up any moral doubts (*Life and Letters of Charles Darwin*, III, 202). Even without anaesthetics, an operation could be justified 'by an increase in our knowledge', and could give the operator protection against

the 'remorse' that would otherwise arise from his procedures (*Descent of Man*, p. 90). The evolution of sympathy allowed the 'surgeon to harden himself whilst performing an operation, for he knows that he is acting for the good of his patient' (*Descent of Man*, p. 159).

Darwin's work on the moral sense was complemented by Herbert Spencer's *Principles of Psychology* (1855).42 Put succinctly, the more evolved the emotional being, the more considered, and the less impulsive, would be the conduct of that being. It would be better equipped to see the long-term consequences of its actions, and to decide on the best overall moral action. 'An emotional nature not well developed', Spencer said, 'will be relatively impulsive — the liability will be for each passion to display itself quickly and strongly, without check from the rest.' With a higher development of the emotions, 'there will be little liability to sudden outbursts of feeling.' The resulting conduct, derived from a more complex and 'a greater number of feelings severally less excited', was likely to be 'more persistent'. Spencer was outlining the contrast between civilized and 'savage', but, as was typical, he averred that an illustration of his theory was 'furnished by the contrast between men and women' (*Principles of Psychology*, I, 583). The overwhelming characterization of antivivisection as a women's cause allowed antivivisectionist arguments to be dismissed in these Spencerian terms.43 The demand for the abolition, or severe curtailment, of vivisection arose from impulsive responses to emotional stimuli. At the apogee of evolution, the white, male physiologists, who were all well versed in Darwinian morals, could claim their greater equanimity.44 All things considered, what they were doing was for the greater good. They could bury their immediate sympathies and carry on.45

Compassion for Spencer was styled the 'tender emotion' or 'pity'. Simply put,

> pity implies [...] the representation of pain, sensational or emotional, experienced by another; and its function as so constituted, appears to be merely that of preventing the infliction of pain, or prompting efforts to assuage pain when it has been inflicted.

This description adequately describes both the objection of antivivisectionists when anaesthetic was not thought to be in use, and physiologists' doubts when anaesthetics were not available, reliable, or preferable for certain experiments. But how did the evolutionists explain the continued presence and persistence of pity even where there was no pain? Spencer drew attention to a 'certain phase of pity' in which 'the pain has a pleasurable accompaniment; and the pleasurable pain, or painful pleasure, continues even where nothing is done, or can be done, towards mitigating the suffering', or even when there is no actual suffering at all. Linking this tendency to the 'parental instinct', which in Spencer tends to indicate the 'maternal instinct', he asked what was the 'common trait of the objects which excite' the feeling. He found that this common trait was

> always relative weakness or helplessness. Equally in the little girl with her doll, in the lady with her lap-dog, in the cat that has adopted a puppy, and in the hen that is

anxious about the ducklings she has hatched, the feeling arises in presence of something feeble and dependent to be taken care of.

Naturally, this extended to 'weakly creatures in general, and creatures that have been made weakly by accident, disease, or by ill-treatment' (*Principles of Psychology*, II, 688–92). This feeling, a tender sympathy, was a self-serving pleasure, compassion *de haut en bas*, that did not serve any far-reaching good.46 It accounted for what Gertrude Himmelfarb has called 'the corrupt version of the gift as practised by a lady bountiful'.47 Spencer called this 'ego-altruism'.48 New knowledge of the natural causes of the moral sentiments would bring this to an end and 'call in question the authority of those ego-altruistic sentiments which once ruled unchallenged'. The moral sentiments, once fully evolved, were to 'prompt resistance to laws that do not fulfil the conception of justice, [and] encourage men to brave the frowns of their fellows by pursuing a course at variance with customs that are perceived to be socially injurious'.49 For physiologists and their supporters, antivivisectionist sympathy was deemed socially injurious in evolutionary terms and the pursuit of physiology was thought to be worth the frowns of (the less-evolved representatives of) society. Huxley perhaps said it most clearly when he wrote of the need of 'putting natural sympathy aside, to try to get to the rights and wrongs of the business from a higher point of view, namely, that of humanity, which is often very different from that of emotional sentiment'.50

Putting the moral good of vivisection in these terms, it now becomes clear that the utilitarian argument put forward in the defence of physiology — that vivisection was justified by its humanitarian ends — was precisely aimed at addressing the anti-vivisection claim that physiology had blunted the compassion of its practitioners. In fact it asserted a superiority of compassion apparently beyond the grasp of antivivisectionists.51 The argument was already strong without having recourse to the additional safety of anaesthetics, which, after the 1876 Bill to regulate their usage had passed into law, implicitly undergirded the majority of humanitarian claims put forward in favour of physiology.52

If the last quarter of the nineteenth century underwent a significant and general shift in the meaning and practical applications of compassion, as Gertrude Himmelfarb has convincingly argued in *Poverty and Compassion*, this article demonstrates that the adoption of a 'Religion of Humanity' was by no means uncontested. The intellectual and social impetus that drove 'humanitarians' to their 'Religion of Humanity' depended both upon the construction and direction of compassion, or sympathy more generally, and the degree to which 'natural-law' reconfigurations of moral action were set against prevailing notions of moral sentiments and aesthetic sensibilities. The encounter between compassion driven by an emotional/aesthetic

response and compassion as an abstract judgement manifested two coeval and entangled 'moral economies': distinct webs of 'affect-saturated values' with their own systematized and normalized notions of right conduct.53

The analysis of this encounter allows us to understand why antivivisection agitation actually increased in the period after anaesthetic usage had been legislated, regulated, and monitored. Despite physiologists' untiring and consistent pleas that anaesthetics were used and were wholly effective in eliminating pain, antivivisectionists continued to protest in any case.54 These protests centred on the perceived moral danger of the image of the opened body and of the sight of blood, irrespective of the presence of pain. Stewart Richards has shown that even after 1876, antivivisectionists found laboratory activities distasteful or repulsive, styling this as an 'aesthetic objection'. He explains that, even after anaesthetics had seemingly robbed antivivisectionists of their moral cause, the cause nevertheless continued on the basis of 'revulsion generated by the supposed aura of the laboratory as a hybrid product, as it were, of the operating room and the slaughterhouse'. Vivisection 'had become indelibly associated with ideas of ruthless interrogation, offensive air and, above all, with blood'.55 Antivivisectionists considered scientists to be just as brutalized by repeated exposure to the sight of blood as by their infliction of pain. This was a dulling of the aesthetic sense, of an instinctive sympathy, in societal leaders and public men, that might precipitate a general spread of brutality throughout society. The most ardent of antivivisectionists therefore saw the advance of physiology as the corrupt offshoot of Darwinian morals. 56 Frances Power Cobbe famously asked if

> the principles of the evolution philosophy require us to believe that the advancement of the 'noble science of physiology' is so supreme an object of human effort that the corresponding retreat and disappearance of the sentiments of compassion and sympathy must be accounted as of no consequence in the balance.57

Richard Hutton (editor of the *Spectator* and a leading antivivisectionist) thought that 'common compassion', the very thing that evolutionary ethicists had disavowed, had collided with 'the pursuit of scientific truth'. For him, 'the ends of civilization, no less than of morality' required that this common compassion, the aesthetic sense of sympathy, be followed.58 Indeed, the brutalized scientist himself, inured to the commission of painful acts and/or to the sight of blood, was the principal cause of antivivisectionist fear. Antivivisection's 'sentiment of distaste' — an 'aesthetic judgement' — was completely consistent with a judgement 'in universal (moral) terms'.59 An unfeeling man, judged by his insensitive eye, was an immoral man.

The antivivisectionist argument was sophisticated on this point. In allowing for a great expansion of animal experimentation, the legally enforced use of anaesthesia after 1876 was thought to have accelerated the numbing of the physiologists' own aesthetic sense. This risked their own, and ultimately everyone else's, moral sense. The first proof of this was, perhaps self-

fulfillingly, in antivivisectionists' own treatment at the hands of medical scientists, which might be classified as disregard at best and hostile dismissal at worst. As a body claiming to represent public opinion, antivivisectionist fears were not activated principally by physiology's lack of feeling for animals, but by physiologists' apparent lack of regard for *them*, or for public feeling at large. Frances Power Cobbe feared that without instinctive disgust, hearts 'curarized' by 'science teaching' 'beat no more with any emotion of indignation or pity'. The institutional *raison d'être* of the Victoria Street Society, the principal organization opposed to vivisection, was to

> preserve the whole community [...] from the deadliest possible injury, namely, the suppression of compassion, and the fostering of selfishness and cruelty, in the high places of education from whence those vices must permeate the whole character of the nation.60

Antivivisectionist outrage fits into a view, consistently held since Adam Smith's *Theory of Moral Sentiments* (1790), on what happens when compassion, or sympathy, is thought to have failed. It signalled the breakdown of civilization.61

Adam Smith, at any rate, would have understood antivivisectionist rage at physiologists' 'cold insensibility and want of feeling', but he would have also drawn the physiologists as 'confounded' at the antivivisectionists' 'violence and passion'. Indeed, the two camps had 'become intolerable to one another'.62 This failure was precipitated by the perception of science's increasing distance from public opinion, a novelty perceived in some quarters as the dangerous and immoral drift of society toward specialization and professionalization.63 Antivivisectionist 'pain' in the form of an aesthetics of compassion may have been irrational in utilitarian terms, but science's cold response was styled as inhuman. Civilization was risked not by vivisection, but by the character of the men who carried it out.

Physiologists departed from this position with the conviction, first, that aesthetically based moral sentiments could be flawed, and second, that evolutionary scientists better understood the highest ends of moral action. Compassion was projected to suffering humanity in the abstract and was out of place with regard to the sight/site of suffering in the laboratory, especially if there was actually no physical suffering. Those men who had already given preference to the cause of science over scruples about the infliction of pain, and the self-infliction of emotional pain, undoubtedly felt a greater release from the immediate aesthetic impulse of compassion, pity, humanity, or tenderness, through the use of anaesthetics. Moreover, anaesthetics allowed a great many further scientists to swell the ranks of physiology without the need to scruple about pain in the laboratory. This was considered to be an enrichment of the action of 'humanity', for it had humanity as a species as its object. Through

this conception of humanity, the historian can more readily identify the imperturbable scientist, anaesthetized to the sight of blood, and callous for the sake of what he deemed a greater compassion.

Figures

References:

1. Bouchard, Gérard. The Making of the Nations and Cultures of the New World: An Essay in Comparative History. Trans. Michelle Weinroth and Paul Leduc Browne. Montreal: McGill-Queen's UP, 2008.2. Patrizia Guarnieri, 'Moritz Schiff (1823–96): Experimental Physiology and Noble Sentiment in Florence', in *Vivisection in Historical Perspective*, ed. by Nicolaas A. Rupke (London: Croom Helm, 1987), pp. 105–24 (p. 106).

3. Stewart Richards, 'Drawing the Life-Blood of Physiology: Vivisection and the Physiologists' Dilemma, 1870–1900', *Annals of Science*, 43 (1996), 27–56 (pp. 31, 47–48). See also Hilda Kean, '"The Smooth Cool Men of Science": The Feminist and Socialist Response to Vivisection', *History Workshop Journal*, 40 (1995), 16–38 (pp. 19, 23).

4. Paul S. White, 'The Experimental Animal in Victorian Britain', in *Thinking with Animals: New Perspectives on Anthropomorphism*, ed. by Lorraine Daston and Gregg Mitman (New York: Columbia University Press, 2005), pp. 59–82 (pp. 62, 74). White's appraisal of the emotional control of physiologists is given richer treatment in 'Sympathy under the Knife: Experimentation and Emotion in Late Victorian Medicine', in *Medicine, Emotion and Disease, 1700–1950*, ed. by Fay Bound Alberti (Basingstoke: Palgrave, 2006), pp. 100–24. See also Donald Fleming, 'Charles Darwin, the Anaesthetic Man', *Victorian Studies*, 4 (1961), 219–36.

5. Paul White, 'Introduction', *Isis*, 100 (2009), 792–97 (p. 796).

6.For nineteenth-century attitudes towards vivisection, see Stewart Richards, 'Anaesthetics, Ethics and Aesthetics: Vivisection in the Late Nineteenth-Century British Laboratory', in *The Laboratory Revolution in Medicine*, ed. by Andrew Cunningham and Perry Williams (Cambridge: Cambridge University Press, 1992), pp. 142–69. For a positive account of how 'saving pain' was 'consonant with the very essence of modern civilization', see Stephanie J. Snow, *Blessed Days of Anaesthesia: How Anaesthetics Changed the World* (Oxford: Oxford University Press, 2008), pp. 155–58 (p. 164).

7.The generic physiologist in this period was always represented as male. I shall preserve that prejudice as inherent to the story. The monstrous character of Dr Moreau gains his verisimilitude from the complexity with which he approaches the problem of pain and sympathetic pain. Some of Moreau's explanations reflect contemporary physiology's well-intentioned justifications for vivisection. See H. G. Wells, *The Island of Dr. Moreau* (London: Heinemann, 1921), pp. 92, 94. For a compelling contextualization of the Victorian mad scientist in literature, see Anne Stiles, *Popular Fiction and Brain Science in*

the Late Nineteenth Century (Cambridge: Cambridge University Press, 2012), esp. chapter 4.

8.E. Klein and others, *Handbook for the Physiological Laboratory*, ed. by John Burdon-Sanderson, 2 vols (London: Churchill, 1873). See also Richard D. French, *Antivivisection and Medical Science in Victorian Society* (Princeton: Princeton University Press, 1975); and *Vivisection in Historical Perspective*, ed. by Rupke.

9.UK Parliament, Report of the Royal Commission on the Practice of Subjecting Live Animals to Experiments for Scientific Purposes, C. 1397 (1876), pp. 32–34, 36. Subsequent references are to the Royal Commission on Vivisection.

10.See Royal Commission on Vivisection, testimony of Thomas Watson, p. 4; William Sharpey, pp. 25–26; and Alfred Swaine Taylor, p. 60.

11. David Ferrier, 'The Croonian Lecture — Experiments on the Brain of Monkeys', *Philosophical Transactions of the Royal Society of London*, 165 (1875), 433–88.

12. *The Times*, 4 August 1875, p. 7.

13. Royal Commission on Vivisection, p. 12. The quotation is from the question put to Burrows by Viscount Cardwell.

14.Royal Commission on Vivisection, p. 17. The point was echoed by Alfred Swaine Taylor of Guy's Hospital, p. 57. A fuller statement to the same effect was made by John Simon, p. 75.

15. Royal Commission on Vivisection, p. 29. The point was reinforced by John Simon, p. 75, and Phillip Henry Pye-Smith, p. 109. The major dissension from this view came from Arthur de Noé Walker, who had witnessed vivisection predominantly without the presence of anaesthetics, and mainly outside of Britain, esp. p. 246.

16. *The Times*, 25 April 1881, p. 10. For Romanes's exemplary qualifications as a vivisector, and Darwin's involvement in pro-vivisection, see Rob Boddice, 'Vivisecting Major: A Victorian Gentleman Scientist Defends Animal Experimentation, 1876–85', *Isis*, 102 (2011), 215–37.

17. See George John Romanes, *Jelly-fish, Star-fish, and Sea-urchins: Being a Research on Primitive Nervous Systems* (London: Kegan Paul, Trench, 1885), pp. 6–9.

18. Edmund Gurney, 'A Chapter in the Ethics of Pain', *Fortnightly Review*, n.s., 30 (1881), 778–96 (pp. 780, 783, 786–87). Charles Darwin was largely in agreement with Gurney: see *The Life and Letters of Charles Darwin*, ed. by Francis Darwin, 3 vols (London: Murray, 1887), III, 210. See also W. Collier, 'The Comparative Insensibility of Animals to Pain', *Nineteenth Century*, 26 (1889), 622–27 (p. 622).

19.John Stuart Mill, 'Utilitarianism (1863)', in *Utilitarianism, Liberty, Representative Government*, ed. by H. B. Acton (London: Dent, 1972), pp. 7–9; Cf. Collier, p. 623.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

20. ohn Simon, 'An Address delivered at the opening of the Section of Public Medicine', *British Medical Journal*, 6 August 1881, pp. 219–23 (p. 223). See also William B. Carpenter, 'The Ethics of Vivisection', *Fortnightly Review*, n.s., 31 (1882), 237–46 (p. 246).

21. Emanuel Edward Klein was the most famous example of one who asserted that this was the only reason he used anaesthetics, although he later recanted that assertion. See Royal Commission on Vivisection, pp. 183–85, 328. See also Richards, 'Drawing the Life-Blood of Physiology', p. 41; and Bruno Atalic and Stella Fatovic-Ferencic, 'Emanuel Edward Klein — The Father of British Microbiology and the Case of the Animal Vivisection Controversy of 1875', *Toxicologic Pathology*, 37 (2009), 708–13.

22. Carolyn Burdett, 'Is Empathy the End of Sentimentality?', *Journal of Victorian Culture*, 16 (2011), 259–74 (pp. 269–70).

23. William Osler, 'Aequanimitas', in *Aequanimitas: With Other Addresses to Medical Students and Practitioners of Medicine*, 2nd edn (Philadelphia: Blakiston's, 1925), pp. 3–11 (pp. 3–6).

24.The rise of physiology came late enough to adopt the post-mesmeric simplicity and objectification of chloroform. See Alison Winter, *Mesmerized: Powers of Mind in Victorian Britain* (Chicago: Chicago University Press, 1998), p. 184.

25. Cf. White, 'Sympathy under the Knife', pp. 112–14.

26. In addition to the examples given, see also George Fleming, 'Vivisection and the Diseases of Animals', *Nineteenth Century*, 11 (1882), 468–78, on the importance of vivisection to veterinary medicine; James Paget, Richard Owen, and Samuel Wilks, 'Vivisection: Its Pains and Its Uses', *Nineteenth Century*, 10 (1881), 920–48.

27. Lady Burdon Sanderson, *Sir John Burdon-Sanderson: A Memoir* (Oxford: Clarendon Press, 1911), p. 157.

28. Klein and others, *Handbook for the Physiological Laboratory*, II, plate LXXXIX, fig. 226; XCII, fig. 237; XCIII, fig. 242; CXII, fig. 308; CXIV, fig. 310; CXV, fig. 316.

29.

Thomas Lauder Brunton, 'Vivisection and the Use of Remedies', *Nineteenth Century*, 11 (1882), 479–87 (pp. 479–80).

30. *Spectator*, 47 (1874), 13–14.

31. Osler testified before the second Royal Commission on Vivisection in 1907. See UK Parliament, Appendix to the Fourth Report of the Commissioners, C. 3955 (1907), pp. 160, 163.

32. For Osler see the seminal biography by Harvey Cushing, *The Life of Sir William Osler*, 2 vols (Oxford: Clarendon Press, 1926); and the more recent treatment by Michael Bliss, *William Osler: A Life in Medicine* (Oxford: Oxford University Press, 2007).

33. Osler, 'Aequanimitas', pp. 3–6. For Osler's support of vivisection, see Cushing, II, 794–95; Bliss, p. 248.

34. UK Parliament, Appendix to the Fourth Report of the Commissioners, pp. 158, 160–61, 163.

35.'The International Medical Congress', *British Medical Journal*, 13 August 1881, pp. 300–04 (p. 301).

36.Gerald F. Yeo, 'The Practice of Vivisection in England', *Fortnightly Review*, n.s., 31 (1882), 352–68 (pp. 358, 360); William W. Gull, 'The Ethics of Vivisection', *Nineteenth Century*, 11 (1882), 456–67 (pp. 458, 462, 466).

37.*Life and Letters of Charles Darwin*, III, 204. See also *More Letter of Charles Darwin*, ed. by Francis Darwin, 2 vols (London: Murray, 1903), II, 435–41; *Life and Letters of Thomas Henry Huxley*, ed. by Leonard Huxley, 2 vols (London: Macmillan, 1900), I, 436–41.

38.On Romanes, Darwin, and Burdon-Sanderson, see Boddice, 'Vivisecting Major', esp. p. 14; for Huxley, see Stephen Catlett, 'Huxley, Hutton and the "White Rage": A Debate on Vivisection at the Metaphysical Society', *Archives of Natural History*, 11 (1983), 181–89 (p. 185); Spencer was thus quoted in Albert Leffingwell, *An Ethical Problem; or, Sidelights upon Scientific Experimentation on Man and Animals*(London: Bell, 1916), p. 9.

39.Robert J. Richards, *Darwin and the Emergence of Evolutionary Theories of Mind and Behavior* (Chicago: University of Chicago Press, 1987), pp. 121, 239.

40.Charles Darwin, *The Descent of Man, and Selection in Relation to Sex,* intr. by James Moore and Adrian Desmond (London: Penguin, 2004), pp. 147–49.

41.*The Times*, 18 April 1881, p. 10.

42.Darwin, *Descent of Man*, pp. 119–72;Herbert Spencer, *Principles of Psychology*, 3rd edn, 2 vols (London: Williams and Norgate, 1890; repr. Osnabrück: Zeller, 1966). For Spencer, see Thomas Dixon, *From Passions to Emotions: The Creation of a Secular Psychological Category* (Cambridge: Cambridge University Press, 2003), pp. 135–79; and *The Invention of Altruism: Making Moral Meanings in Victorian Britain* (Oxford: Oxford University Press, 2008), pp. 181–221.

43.For antivivisection as feminist movement, see Coral Lansbury, *The Old Brown Dog: Women, Workers, and Vivisection in Edwardian England* (Madison: University of Wisconsin Press, 1985); Mary Ann Elston, 'Women and Anti-vivisection in Victorian England, 1870–1900', in *Vivisection in Historical Perspective*, ed. by Rupke, pp. 259–94; Ian Miller, 'Necessary Torture? Vivisection, Suffragette Force-Feeding, and Responses to Scientific Medicine in Britain c. 1870–1920', *Journal of the History of Medicine and Allied Sciences*, 64 (2009), 333–72. For the problematic association of women (as emotion-

al creatures) with the antivivisection movement, see Joanna Bourke, *What It Means to be Human: Reflections from 1791 to the Present* (London: Virago, 2011), pp. 95–96, 103, 106–07, 168.

44.See Rob Boddice, 'The Manly Mind: Re-visiting the Victorian "Sex in Brain" Debate', *Gender and History*, 23 (2011), 321–40.

45.Paul White has given an effective critique of the 'late-Victorian denigration of sentimentality' and its relation to an 'assertion of scientific and social dominion of feeling' in his article, 'Darwin Wept: Science and the Sentimental Subject', *Journal of Victorian Culture*, 16 (2011), 195–213 (p. 212).

46.David Konstan, *Pity Transformed* (London: Duckworth, 2001), p. 12.

47.Gertrude Himmelfarb, *Poverty and Compassion: The Moral Imagination of the Late Victorians* (New York: Vintage, 1991), pp. 197–98.

48.See Dixon, *The Invention of Altruism*, pp. 196–97.

49.Herbert Spencer, 'Morals and Moral Sentiments', *Fortnightly Review*, n.s., 9 (1871), 419–32 (p. 432).

50.*Life and Letters of Thomas Henry Huxley*, I, 436 [letter of 1890].

51.Cf. Richards, 'Anaesthetics, Ethics and Aesthetics', pp. 143–44, 148.

52.39 & 40 Vic. c.77 (1876).

53.Lorraine Daston, 'The Moral Economy of Science', *Osiris*, 2nd ser., 10 (1995), 2–24 (pp. 4–5).

54.Anaesthetics were referenced thirty-eight times in the fifteen pages of the Report of the Royal Commission on Vivisection. Its recommendations depended on anaesthetics.

55.Richards, 'Anaesthetics, Ethics and Aesthetics', p. 165.

56.Frances Power Cobbe, 'Darwinism in Morals', in *Darwinism in Morals and Other Essays* (London: Williams and Norgate, 1872); *The Times*, 19 April 1881, p. 8.

57.*The Times*, 19 April 1881, p. 8.

58.Hutton was the sole dissenter from the Royal Commission's final report. The quotation is from his 'Minority Report', Royal Commission on Vivisection, p. xxii.

59.Richards, 'Anaesthetics, Ethics and Aesthetics', pp. 165–68.

60.Frances Power Cobbe, 'The New Benefactor of Humanity', *Zoophilist*, 4, n.s., 3 (July 1884); *Zoophilist*, 7, n.s., 2 (June 1887).

61.Adam Smith, *The Theory of Moral Sentiments*, ed. by Ryan Patrick Hanley, 250th anniversary edn (New York: Penguin, 2009).

62.Smith, p. 27; see also Michael L. Frazer, *The Enlightenment of Sympathy: Justice and the Moral Sentiments in the Eighteenth Century and Today* (Oxford: Oxford University Press, 2010).

Article

Illocutive analysis of the emotive language in English

Kenul Abdurehmanova

Department of lingvo-culture, University of languages of Azerbaijan, The Republic of Azerbaijan, Baku city, kenulchik@gmail.com

Abstract

The following article talks about illocutive analysis of emotive language in English. Since language is an important mean of communication between human beings, it is held that writers or speakers can affect their readers or hearers by using certain linguistic means. The study identifies discursive and linguistic features, which realize cognitive, emotive, parallel and reactive empathy and suggests that imitation, simulation and representation could be non-exclusive processes. The manipulation of semantics and syntax, namely the use of emotive language is seen as an affective means resorted to by text producers to influence the people's acceptance of the truth. Emotional language aims ultimately at persuading the addressee to accept the facts as they are presented by writers. It is regarded as a necessary condition for persuasion to be successful. This is due to the persuasive force of emotive meaning exerted upon the receiver.

Keywords: emotive, speech act, illocution, text,

Introduction

According Wikipedia Illocutionary act is a term in linguistics introduced by the philosopher John L. Austin in his investigation of the various aspects of speech acts. For example, in uttering the locution "Is there any salt?" at the dinner table, one may thereby perform the illocutionary act of requesting salt, as well as the distinct locutionary act of uttering the interrogatory

sentence about the presence of salt, and the further perlocutionary act of causing somebody to hand one the salt.

The notion of an illocutionary act is closely connected with Austin's doctrine of the so-called 'performative' and 'constative utterances': an utterance is "performative" if, and only if it is issued in the course of the "doing of an action" (1975, 5), by which, again, Austin means the performance of an illocutionary act (Austin 1975, 6 n2, 133). According to Austin's original exposition in How to Do Things With Words, an illocutionary act is an act (1) for the performance of which I must make it clear to some other person that the act is performed (Austin speaks of the 'securing of uptake'), and (2) the performance of which involves the production of what Austin calls 'conventional consequences' as, e.g., rights, commitments, or obligations (Austin 1975, 116f., 121, 139). Thus, for example, in order to make a promise I must make clear to my audience that the act I am performing is the making of a promise, and in the performance of the act I will be undertaking an obligation to do the promised thing: so promising is an illocutionary act in the present sense. Since Austin's death, the term has been defined differently by various authors.

The methodological base of the research were the ideas and concepts presented in the works of domestic and foreign linguists in the field of language and emotion in general, in particular emotion at the lexical level (NA Lukianov, TV Matveeva, VN Telia, and B. Arnold, D. E. Rosenthal, VV Vinogradov, ND Shmelev, W. Chafe, E. Parr, EM Galkina,Fedoruk V.I. Shahovsky, EM Wolf, R. Kiselev, ND Arutyunov, VK Kharchenko, EY Myagkova, AA Reformatsky, MA Telenkova, F. Buslaev, Shakhmatov, L. Bloomfield NS Pospelov, O. Jespersen, IR Halperin); in pragmatics (Charles W. Morris, John. Searle, V. Stepanov, George. Austin L. Schaff, D. Lyuiz, SK Ogden, E. Benveniste, VI Karasik, LA K. Graudina, ND Arutyunov, LV Gromozdova); Translation (AD Schweitzer, VG Gak, Yu Lwin, K.I. Chukovsky, AV Fedorov, T. Found LK Latyshev, O. Kade, U. Weinreich, A. Neubert, RK MinyarBeloruchev A. Kurella).

History research emotive text

At the beginning of the XIX century Wilhelm von Humboldt noted that language as a human activity full of feeling. Since linguists began to study the language in close contact with a person, including his emotions, this issue so far seems to have been exhausted. But despite the almost comprehensive study in linguistics concepts such as "emotional", "projected", "emotiveness", "expressive", "connotation" in some writings, they continue to be used interchangeably, which is not surprising, since all these concepts - spokesmen subjective opinion of the speaker, which may relate to the subject of speech situation, the interlocutor. We consider it necessary to distinguish between the understanding and meaning of these terms, to explore the dif-

ferences in their use. All that the individual is aware of at this point in time, can be divided into two parts: that relates to external objects of the world perceived by the senses, and that is coordinated with the subjectivity, which includes everything relating to the inner world of the individual, his I-thoughts, experiences, and other (Beardsley, 1958, p. 34), and "emotion included in both parts of consciousness, resulting in interpenetration rational and emotional" (Shakhovskiy, 2002, p. 112). The subjectivity of the speaker has the ability to represent itself as the subject; its foundation lies in the process of language use, and enables two-sided subjectivity of language communication (Benevist, 1974, p. 296). Indeed, it is difficult to imagine it without an expression of this very subjectivity: first and foremost, without personal pronouns referred to time and place, without emotion. Scientists have long tried to isolate from the variety of human emotions so-called basic, basic or primary (see: Plutchik, Kemper, A. Wierzbicka), while A. Wierzbicka argues that such a range of emotions depends on the mother tongue (Wierzbicka, 1999p. 505). E.M. Wolf separates the specific emotional states (such as joy, anger) with a certain character from nonspecific emotions (e.g., anxiety, nervousness), which indicate the deviation from the norm, tranquility without specifying the nature of emotions (Wolf, 1985, p. 59). However, in every language there are categories or concepts such as "happiness", "sadness" and others, and certainly there are different ways of expressing these emotional experiences. Emotions as a psychic reality are reflected in all the works of human speech. On the other hand, emotions affect the characteristics of perception. In the case of a language picture of the world representation emotions included in this picture of the world as an object of reflection and at the same time create opportunities simulated world, because they themselves are the way of reflection.

This dual nature of emotions manifested in language and speech. Namely, the distinguished linguistic means of expressing emotions (emotions act as a way of reflection) and language tools for describing emotions (emotions serve as an object of reflection). There is a constant mutual influence of the real world and emotional state. On the one hand, the perception of the world and its reflection in language and speech depends on the emotional state of a person.

On the other hand, the surrounding reality, reflected in human consciousness affects his emotions through the evaluation mechanism.

One of the main features of the text of a work of art is its anthropocentric character as a subject of the image is a man with his thoughts, actions, feelings and emotions. Emotions- integral part of human existence, so the writer (author), creating a work of art, not only describes the objects, phenomena, events, but also penetrates into the sensual sphere of existence, describes the emotional state of a person (character),

while expressing their own (or character) emotional attitude to the situation described. Thus, in the text of a work of art the author creates emotive fragments «from author "or «from hero."

In recent years, the interests of linguists increasingly rush to the study of "human feelings". The realization that "language is the heart" and "a heart language" leads to the creation of new works, which studied the interaction of emotions and language.

The study of emotion as a linguistic category has a long history of linguistic, as the ancient philosophers have noted influence on the verbal behavior of the individual test them (under the influence of various causes) emotions. Currently, many leading scientists have attempted to diversify explore emotional language from different angles and positions. Thus, the process of formation of emotional language is inextricably linked to the various aspects of psychology and physiology (Vygotsky (1934), Penfield (1964), Rubinstein (1973), Vasiliev (1980), Wolf (1996)), linguistics (Pierce (1958), Benveniste (1974), Avrorin (1975) Wierzbicka (1999) Shahovsky (2002)). But until now, scientists' opinions differ on many issues relating to the interpretation of the term, the structural and semantic components of this class, its borders, and values. In addition, the study of the language of emotion almost did not affect the area of pragmatics, while the interest in the proper communication of the statements by linguists constantly growing, there is a large number of scientific papers devoted to the comprehensive study of the pragmatic function of language, development and unification of the theory of speech acts, which analyzes the process of generation and perception of information classified types of speech acts, explores the final communicative effect and how to maximize the impact on the addressee (Morris (1983), Arutyunova (1997), Pelts (1999), Lyuiz (1983), Austin (1999) Searle (1986)). Language emotion includes means to implement at different levels. Class emotionally-estimated lexicon - the most agile and open class language, at the same time he was actively used in speech communication, as a universal means of expression of subjectivity. The linguistic nature of the emotional-evaluative vocabulary allows it to be implemented very wide and varied, is a leading component in terms of human speech, while still unresolved questions remain concerning the interpretation of the term, grading and classification, the boundaries of the class. Most controversial in the emotional structure of the language is a class of interjections, despite the centuries-old experience of its study and description (Shakhmatov (1941), Arnold (1959) Vinogradov (1975) and others). The inclusion of interjections in the class of vocabulary in general, in the broadest sense, and in Division emotional vocabulary - in the narrow, resolved ambiguous because of extraordinary linguistic nature of interjections that have features of both significant and words (Kruchinina (1998),

Jespersen (1958), Vinogradov (1975), Bloomfield (1968)). This similarity with the class of interjections emotionally-estimated lexicon is most evident in their analysis from a pragmatic point of view. Differentiation interjections often limited by their structural features or emotional semantics in the absence of in-depth analysis of each subclass. In this paper, we tried to put together a variety of viewpoints on the nature of the emotional-evaluative vocabulary at all, to streamline its terminology and classification. The interest in expressive language originated after been adequately studied nominative proper sphere, as emotions - "a form of reflection of the world, indicating the spiritual experiences, a sense of excitement" (Shakhovskiy, 2002, p. 181). For a long time in domestic science was dominated by a formal approach to the definition of the emotional component of lexical meaning, because sometimes even the linguist has difficulty in explaining the preference of either option. The presence of the word emotionally-estimated color is sometimes defined as an assignment to the functional style of "emotional expression evaluation is based on various stylistic tightness marked synonymous words (above neutral: high, Poet., Book; below neutral: SPEECH, Simple, and others) that is the basis of the positive or negative qualification referred to the object "(Novikov, 1990, p. 446). But to say that all the lofty words are positive, and conversational and colloquial - negative emotional, it would be incorrect (Shevchenko, 2003, p. 28), as it is impossible to underestimate the importance of context in determining the negativity / positivity, emotional / neutrality, as well as the presence in the language of words, the structure of which is already emotional and evaluative component. For example, the presence of emotional coloration indicates the impossibility of such combinations (in this case refers to the orientation of ironic): "I thank you for cowardice," "damn right" (Sklarevskaya, 1978, p. 67). Thus, "the actual stylistic Sticky words and expressive orientation are two different characteristics" (Shmelev, 1997, p. 166). Domestic linguistic tradition does not allocate expressive lexical units as a separate class, and considers them from different angles: the semantic, psychological, socio-linguistic, physiological, and others. Modern science does not clearly distinguish between these two approaches, emphasizing their relationship and interaction. For example, some psychologists, on the basis of experiments conducted, argue that the emergence of emotions and equally important physiological reasons, and understanding the situation. For example, a meeting with an armed man in a dark alley can cause physiological arousal, but the emotion of fear is determined by the cognitive interpretation that may result in this situation (Wolf, 1996, p. 139). From the point of view of semiotics, emotion - it is also a sign, along with the sign-person sign-thought. Even Charles S. Peirce pointed out: "Everything is for us the slightest interest in us is special, even a minor emotion" (Peirce, 1983, p. 67).

Vygotsky was in isolation from the intellectual side of consciousness affective saw one of the major defects of traditional psychology. According to him, between the emotional and intellectual process of thinking there is a natural link: "Who tore thinking from the beginning of the passion, he always closed his way to an explanation of the reasons for thinking, because thinking involves the analysis of autopsy motive thoughts, needs and interests, motives and trends that guide the movement of thought in one direction or another "(Viqotskiy, 1934, p. 14). S.L. Rubinstein considers thinking as a set of intellectual and emotional, and emotion - as a set of emotional and intellectual (Rubinstein, 1973, p. 97-98), and the qualitative difference is the predominance of one or another component. Emotions are part of human intelligence. And the formation of consciousness, according to I.A. Vasilyev, VL and Poplozhnomu O.K. Tikhomirov, occurs during an emotional activity as activism can not be impartial, consequently, stands out not rational consciousness and emotional dominant, we cannot think or speak without emotion (Vasilyev, 1980, p. 30). In addition, it is proved that in the process of remembering emotional information is absorbed quickly neutral, because the emotional memory of involvement of "animating emotional traces of previously experienced person, that is, the transfer of his emotional experience from one situation to another" (Penfield, 1964, p. 210). Theories about what emotions are preverbal component of cognition, held by many scientists, including William Gray, C. Bally. W. Gray argues that all knowledge is encoded emotions, this view is supported and psycholinguists who claim that there is no emotive language-neutral, and all emotive language.

Emotion, intelligence and thinking - kind of indissoluble unity, with some scholars acknowledge the existence of emotional intelligence - the human ability not just to express any emotion and express it according to the situation, but for a successful communication the interlocutors must have a "common emotional center of coordination communication "(Shakhovskiy, 2002), otherwise they can expect failure. It's hard not to agree with the considered views, no doubt, emotions play a decisive role not only in behavior but also in acts of consciousness of human cognition.

For any person "naturally react emotionally to the world" (Telia, 1981, p. 203). Emotional function of language, according to VA Avrorin is leading, along with the main - communication (Avrorin, 1975, p. 34). This emotion often manifested in oral language. Wrote Vinogradov, "colloquial vocabulary usually inherently emotionally painted saying" (Vinogradov, 1975). In addition, "most emotive cause, in some cases mobility of semantic boundaries of spoken words, they acquire additional connotations, can easily become a multivalued" (Qalperin, 1958, p. 83); it is often colloquial vocabulary has a bland subject-logical meaning, namely "tone and expres-

sion as the methods of communication are made albeit not before the words or phrases, but, in any case, at the same time with them" (Losev, 1982, p. 23). In psychology and common use, emotion is an aspect of a person's mental state of being, normally based in or tied to the person's internal (physical) and external (social) sensory feeling (Zhang et al., 2008). Emotion identification from natural language texts has drawn the attention of several information processing communities, e.g. reviews (Turney, 2002), news (Lin et al., 2007), Question Answering (Wilson et al., 2005), Information Retrieval (Pang and Lee, 2008).
Several efforts have been made by the natural language processing researchers to identify emotion at different level of granularities such as word, sentence or document (Ku et al., 2006; Das and Bandyopadhyay, 2009b; Das and Bandyopadhyay, 2010). But in many domains of text, the values of individual phrases may bear little relation to the overall sentiment expressed by the text. Just like words, phrases are considered as the informative and emotion expressive units of any sentence and are used in identifying document level emotion tags (McDonald et al., 2007). Hence, the current dependence on individual word level information to identify sentential emotion has motivated the search for phrase level clues.

The emotive meaning of a word can be clearly understood if we introduce the notion of neutral meaning. It denotes the unemotional communication: Stylistic of emotional word and constructions are easily sensed when they are set against the non-emotional words and constructions. Linguistic pragmatics as a way of functional characteristics of emotionally-estimated lexicon

The structures of emotional and evaluative vocabulary informative and pragmatic functions are equivalent, as one component of a modification entails a modification of the other. There are 4 types of interaction of these things: 1) nuclear informative sema sema + zero pragmatic ("TV", "on», «over», «electricity») - the words, the structure of which there is no connotation, but in a certain context and they can carry out pragmatic function; 2) nuclear informative sema + nuclear pragmatic ("fraud", "muddler», «bull-faced», «murderer»), both components are equal; 3) nuclear informative sema + peripheral pragmatic Skye sema ("miserable», «sad»), the pragmatic function is secondary; 4) nuclear pragmatic sema + peripheral informative sema ("disgusting", "magnificent», «perfect», «delicious»), it is possible to carry and interjections, such words are not used to inform the speaker and, above all, to act for destination (Kiseleva, 1978, p. 83). The Trace seed differentiated according to the following types: 1) substantive ("walk"); 2) deictic ("I", "you"); 3) relativity ("in", "on"); 4) emotional (interjection) 5) incentive (sh!; hush! empty); 6) emotional appraisal ("ugly"); 7) + substantive emotional appraisal ("rascal"); 8) substantive + expres-

sive ("bang"); 9) substantive + emotionally + estimated intensity ("fall in love") (Kiseleva, 1978, p. 83). Obviously, the first three are related to the type of seed informative (denotative) Sema, the others - with the pragmatic. At the same time to determine its type, it is important inner emotional content of the words of his character and the degree of its severity. Accordingly, we can say that the presence of the semantics of words connotative meaning is reflected in its pragmatic function, so that these components are interrelated and interdependent. Often, it is the emotional and evaluative content of the word defines illocutionary force utterance: it "encourages experience this feeling, attitude and is, ultimately, the realization of a certain illocutionary intention (intention), causing in the case of communicative luck corresponding perlocutionary effect" (Telia, 1981, p. 34). Since neutral lexical units in a certain context may acquire emotion (connotation), and, respectively, and the pragmatic function occasional they become similar to the originally emotional units. Furthermore, the emotional unit engaging with each other in a linear relationship in the utterance, emotional to this increase. For example, in the phrase "Well done!" Interjection in conjunction with emotional and evaluative nouns enhances overall emotional statements (cf.: "Well done!"), Sometimes it subjugates word with weaker emotional coloring. For example, words with negative emotional evaluations change it to positive under the influence of standing next to the words, and vice versa, "Wondrous dog! Rogue "or" poisonous politeness », « terribly beautiful » (Kiseleva, 1978, p. 120). As a part of a pragmatic situation is considered such a thing as a "speech act". Under the speech act is understood speech focused action to be taken in accordance with the principles and rules of verbal behavior adopted in a given society (Arutyunova, 1997 p. 412). Since the speech act - a type of action and it is considered from the point of view of the same categories, as well as any other action: the subject, purpose, method, and tools, tool results, conditions, success and so on. In the speech act involved the speaker and the addressee. By George, Austin speech act created from any of the following components: the utterance of sounds - the construction of statements - statements supply meaning and its correlation with reality - giving focus (illocutionary act) - the impact on the consciousness (perlocutionary act). The functions of the speech act he calls illocutionary forces, which include the target intensity, the way to achieve the target, a feature of the proposition and the individual conditions of the use of the speech act (Austin, 1975, 109). In the speech act in semiotic terms there are four levels: locution, a proposition illocution, perlocution (Austin, p. 16). Of particular importance in the structure of the speech act has acquired the concept of illocutionary function (power), which has the status of a special kind of values that are hierarchically subordinate to the propositional meaning the sum of the

reference and predication. Central to the pragmatic point of view, many scholars recognize it illocutionary act, that it is directly related to its interpretation destination. Still ongoing dispute concerning the connection of the illocutionary and perlocutionary acts; linguists then breed them, and then consolidated in a single unit. In our view, the relationship between these two aspects of the speech act is obvious, since a certain communicative effect should be prepared by certain means, and vice versa. For the formal aspect of the speech act can be attributed linguistic units, intonation, to the content - the value of proposition, pragmatic components (illocutionary function, motive, purpose, strategy impact on the recipient, social and personal characteristics of the participants posts, the emotional state of the participants and perlocutionary effect of communication . In this case, there is often a difficulty in determining the type of speech act, for example, saying "Do not do this," the author tells requests, advises, requires or advises? In this case, an important role in determining the type of speech act plays intentional context as "semantics of individual words and expressions cannot cover all the features at once in a complex speech act". It is a sign of intentional (defined goal, intention) distinguishes illocutionary act of lokutive, and it differs from conventional perlocutionary aspect - selection means for determining exposure. But only in a certain environment situation, the phrase can be interpreted in the sense implied by the author. So, to the phrase "I now pronounce you husband and wife" had the power, it is necessary that it was delivered at a minimum in the situation of marriage. Realization of emotive language at different levels

In the language of the emotions expressed in the categories of emotion, expressive, emotive or estimates. They are implemented in all the languages at different levels: phonetic, morphological, lexical, word-formative, syntactic, stylistic, textual, and communicative by various means of language. Consider the means of expressing emotion in English. On the phonetic level stand out: 1) the variation of sound, "Oh-oh-oh"; 2) soundwriting: «Knock! Knock! He knocked the door »; 3) alliteration: «Roll down-roll down to Rio ...» ; 4) emphasis: «That 'will not do»; 5) accent and intonation means, with the intonation may depend on the type of offer and the individual, situational wishes of the author's statements : «he looked 'me»; 6) sound repetitions, which, according to some authors, "highlight words, make it non-standard, unusual and, as a consequence, expressive, for example:« to murmur »; 7) distortion of familiar phonetic form "sound-crystal-like», «helter-skelter», «riff-raff». In English, the morphological means of expressing emotions include: delineation of suffixes, transmitting emotive, there is a bit different, primarily due to lack of labor. So, affixes -y, -ie, -let («girlie», «birdie», «kinglet») transmit a positive emotional, and adding an affix to the names -ish im-

age-based with negative adjectives, and sometimes with a contemptuous assessment of «bookish », « doggish ». Among the other significant suffixes negative assessment can be called -ard, -eer, -aster; diminutive affixes create words indicating the small size of the object, as well as playfully caressing attitude: -kin («lambkin»), -let («chicklet»); 2) without affixes method of word formation (most conversion), for example: a) interjection: «he thought he was absolutely oops»; b) the derivation of the generating bases: Wed .: «monstrous», where the main indicator becomes a suffix, and the foundation; c) the transposition of words with metaphoric basics: «to desire» - «desirable»; Complicated additional associations: «supermarket voice» ; d) special category - expressive compound words, which are formed by model syntagmas: «Mister know-all»; d) derived from onomatopoeic and sound-symbolic roots: «murmurous», «to miauw»; e) the archaic prefix is not allocated in a modern language (Indo-European language prefix belong to the expressive: «for-give», «cast-away»; g) fusion when motivated word identical syntactic combinations: «forget-me-not», «mother-in-law»; h) abbreviation: «BEST» (Basic Emotional Structuring Test - A. Kaleri).

The same derivative can act as a result of various derivation processes, wherein semantics including generating emotion words often stored in derivatives cf .:, «to thieve» - «thief». At the lexical level, stand out:

1) «you are very green, John»;
2) Internal form, including quantitative («little» in the sense of "Young") and quality («dove») expressiveness, transparent («nevermore»), or blacked out («con»), or is lost with time («estimate» - with the word respect);
3) Words with evaluative component: «failure»;
4) Interjection: Usually these words express our feeling such as regret, despair, sorrow, woe, surprise, astonishment etc. In the previous parts we have spoken about interjections which were defined as expressive means of the language. Emotionally colored features of interjections after conscious and intentional intensification of their structural and semantic properties move up to a generalized status and become a stylistic device.

Interjections may be divided into simple and derivative.

Simple interjections: Oh! Ah! Bah! Pooh! Gosh! Hush! Alas! Vow! Eh! Oh!

Derivative interjections: Heavens! Good gracious! Dear me! Good! By the lord! God knows! Bless me! Hum bug! There are a number of adjectives and adverbs which may be classified as interjections. Among them are the following: terrible, awful, great, wonderful, splendid. When they are used as interjections they are not used in their logical dictionary meanings. In most cases they are used in their emotive meanings as intensifiers.

5) The figurative meaning of the word: «exploit» - «feat" and "exploit" for various

reasons: for the area "man» («owl», «donkey»), the characterization of items related to the person («bushy»), by grounds of the nature of human behavior («thick-skinned»), on the person's mental state («to fire»), by the action («to deplume»), the characterization of social conditions («bread») and others (83, p. 101); 6) A paradoxical inner form: «feisty» - «techy" from «feist» - «evil dog"; 7) Repeat: «pretty-pretty»; 8) Proverb: «it rains cats and dogs»; 9) "folk etymology»: «cutlet», «cut» ; 10) Associative imaginative rethinking of values: «Mother Goose».

Syntax tools include:

1) Asyndeton: «The night sprang to flickering daylight with the gun flashes ...»;

2) Polysyndeton: «The tent is soaked and heavy, and it flops about, and tumbles down on you, and ...»;

3) Inversion: "Out into the bright sunshine stepped Evelyn Coates»;

4) Repeat: «... good-bye, Susan, good-bye, a big car, good-bye, a big house, good-bye power»;

5) Another ellipsis: «In a blue suit»;

6) Subjective modality, which is expressed: a) interjection: «well»; b) opening and modal words: «by the way»; c) word-intensifiers operating amplifying function: «absolutely»; d) Comparative turnover: «He is as mad as a cat that's lost a mouse». 7) Distribution - at a certain linear interaction of neutral lexical units become emotional: «no, no». In the English language are expressive demonstrative pronouns in conjunction with possessive pronouns in postposition: «that rings of yours, that brother of mine».

The textual tools include:

1) The variation of the narrative and structure of parts of the text;

2) Extension, i.e. the presence in the text of any formal characteristics, focusing the reader's attention to some features of the text. Among the subtypes of nomination can be noted: a) convergence, convergence in one spot beam of stylistic techniques, which leads to disruption of the normal compatibility, for example, instead of the «best friend» - «worst friend»; b) the hierarchy, ordering of text, through which there is a transfer of the maximum signal in a minimum of time;

3) Clutch;

4) Failed expectations;

5) A strong position;

6) Game appliqué as "special modification of applicative constructions, built on the principles of the game".

The semantics of emotional words expressed not so much the subject of much attitude. Connotative meaning is the subjective nature of the speech, which manifests itself in the possibility of interpreting the language unit. For example, the word "little eyes" can be as used in the pet and in neglect value. The expressive figurative painting can dominate or sound-symbolic representation («hawk-nosed»), the assessed (, «ardor»), emotional («dove»), quality («bull-faced») Association.

Connotational value not only localized in discrete units of text as a suffix subjective evaluation word, idioms, etc., but also connotation may be present in context and dependent from it. The expressive connotation of the word may be supplemented by such categories as "intensity", which is a potential to actualize the word representation of the subject of a high degree of measure phenomenon or characteristic inherent in the subject , but the very concept of "intensity" does not belong only connotative meanings in nominative words it is associated with denotative content. The structure connotations constituent components may interact with each other. Illocutionary emotional and evaluative words Based on the assertion that in the structure of emotionally-estimated lexicon of nuclear, and, consequently, lead, is it emotional sema, we assume the presence of a certain degree of the illocutionary lexicon. Under illocutionary we followed O.G. Pocheptsov's, ability to understand language units involved in the implementation of speech intention (Pocheptsov, 1986, p. 24), and the degree of emotional and evaluative illocutionary lexicon is considered by us as opposed to the strong and weak positions. This definition is directly position is based on two methods: elimination (omission) or neutralize emotional vocabulary in the statement. With the implementation of these transformations in the absence of any changes (in particular, in the semantic and emotional levels) or if there is almost imperceptible loss sent we qualify as a weak degree of illocutionary. If there are important semantic and emotional levels of losses we qualify the degree of illocutionary emotionally estimated as a strong vocabulary. The study of the influence of emotional and evaluative vocabulary on the formation of a particular type of speech act, the implementation of a certain type of authorial intention, the extent of its influence on the final result speech-production seems to us promising and interesting. It should be noted that we have not been documented cases of neutralization or elimination of statements consisting of emotional words, originally present in the original emotional vocabulary, which also indicates a very high degree of importance to the realization of intentions. As was shown earlier, the omission of emotional and evaluative words deprives the phrase original meaning: «You poor low-life bastard» (Maugham, 2005, p. 157) - «You ...». «This is a foul place» (Sources of illustrative material, Maugham, 1998, p. 197) - «This is a place». «You're ridiculous, Elliott» (Maugham, 1998 p.56)

CONCLUSION

The language of emotions has limitless possibilities for transferring delicate shades of experiencing what is happening through the assessment of a sensual experience, the impact on the destination of the message and the expression. The variety of emotive language means most clearly evident in the text, so it is cognitive-discursive direction of studying emotive category allows us to consider the various facets of this complex

phenomenon as the representation of emotion in speech. Combining the research unit of semantics, pragmatics and stylistics was guaranteed wide integrated approach to the study of emotive on the one hand and in-depth study of each of the aspects of it, on the other hand.

The emotional component that is formed on the verbal level of communication, often implemented through a language category such as "subjectivity", which, in turn, is the basis of linguistic concepts such as "emotional", "projected", "expressiveness." The emotional component may be presented at any level of the language, but the most complex and heterogeneous language classes - in the semantic and formal aspects - is an emotional vocabulary. Attempts to classify it for various reasons were made by many scientists. The class structure of emotional vocabulary categories such as "emotional", "projected", "expressive", brings together the central concept - the connotation, the structure of which all components can function both alone and in close cooperation with each other. But more often draw a clear line between them is not possible, in connection with what is possible to allocate the estimated emotional content of the word. It is closely connected with a pragmatic way to communicate, because the structure of the language unit informative (semantic) and pragmatic (emotionally-estimated), Seme can be correlated with different degrees of implementation of nuclear and peripheral Sem. The statement with the emotional intention of in the first place, aimed at the transfer of the emotional component, and only then - the transfer of certain informative presence of emotional value. The statement on the intention of a neutral aimed to transmit only information plan. Any intention may have two types: emotional and emotionally marked unmarked. The degree of implementation of the illocutionary function of emotional and evaluative words and interjections has some distinctive features as the relationship between the type of intention and semantics emotional valuation unit is installed directly. So, for the emotional and evaluative words, this function is always defined as strong thanks designated semantics. Types value interjections - basic and secondary - influence the implementation of illocutionary functions. That is, for emotional lexical units whose semantics is in a strong position illocutionary function is always realized with a strong degree of influence. For emotional lexical units, the semantics of which is in a weak position, illocutionary function is always sold with a weak degree of influence. Features of realization of illocutionary function, emotional and evaluative vocabulary in the English language are defined as identical, without revealing ethno-specific features. A pragmatic approach to the equivalence of the translation includes an identical expression of communicative intentions and communicative work the same effect on the destination, what is there in the original text. It does not mean the identity of the two texts at all levels,

because there are a number of objective linguistic, situational, cultural differences, which cannot always be overcome. The greatest difficulty in achieving the equivalent translation can be connotative component - both words and speech act. The presence in the text of the translation of various types of translation transformations are not affected directly subclass of emotional and evaluative words and interjections in a strong semantic position, as their semantics is crucial for the realization of the author's intention, and, consequently, their distortion, substitution or absence would lead to non-implementation, distort intentions. Thus, the presence of emotional and evaluative vocabulary in the speech act is always conditioned by certain semantic and structural requirements of the author's statements. Changes in emotional and evaluative component are always to some extent leads to a failure of the implementation of the author's intentions.

References:

1. Alston, William P.. Illocutionary Acts and Sentence Meaning. Ithaca: Cornell University Press. 2000

2. Austin, John L.. How To Do Things with Words. Oxford: Oxford University Press. 1975[1962] ISBN 0-19-281205-X

3. Beardsley M. Aesthetics. Problems in the Theory of Criticism / M. Beardsley. — N.Y., 1958. — 414 p

4. Burkhardt, Armin (ed.). Speech Acts, Meaning and Intentions: Critical Approaches to the Philosophy of John R. Searle. Berlin / New York 1990 ISBN 0-89925-357-1

5. Das. D and S. Bandyopadhyay. 2009b. Word to Sentence Level Emotion Tagging for Bengali Blogs. ACL-IJCNLP 2009, pp. 149-152, Singapore.

6. Das. D and S. Bandyopadhyay. 2009b. Word to Sentence Level Emotion Tagging for Bengali Blogs. ACL-IJCNLP 2009, pp. 149-152, Singapore.

7. Das. D and S.Bandyopadhyay. 2010. Sentence Level Emotion Tagging on Blog and News Corpora. Journal of Intelligent System (JIS), vol. 19(2), pp. 125-134, 2010.

8. Das. D and S.Bandyopadhyay. 2010. Sentence Level Emotion Tagging on Blog and News Corpora. Journal of Intelligent System (JIS), vol. 19(2), pp. 125-134, 2010.

9. Doerge, Friedrich Christoph. Illocutionary Acts - Austin's Account and What Searle Made Out of It. Tuebingen 2006. [1]

10. Ku Lun-Wei, Yu-Ting Liang, and Hsin-Hsi Chen. 2006. Opinion extraction, summarization and tracking in news and blog corpora. AAAI-2006, pp. 100-107.

11. Ku Lun-Wei, Yu-Ting Liang, and Hsin-Hsi Chen. 2006. Opinion extraction, summarization and tracking in news and blog corpora. AAAI-2006, pp. 100-107.

12. Lepore, Ernest / van Gulick, Robert (eds). John Searle and his Critics. Oxford: Basil Blackwell 1991.ISBN 0-631-15636-4

13. Lin K. H.-Y., Yang C. and Chen H.-H. 2007. What emotions news articles trigger in their readers? SIGIR, 733-734

14. Lin K. H.-Y., Yang C. and Chen H.-H. 2007. What emotions news articles trigger in their readers? SIGIR, 733-734

15. Maugham W. Somerset. English story / S. W. Maugham . — M., 2005. — 288 c.

16. Maugham W. Somerset. The Razor's Edge / S. W. Maugham . — M., 1998. — 320 c

17. McDonald Ryan, Kerry Hannan Tyler Neylon MikeWells Jeff Reynar. 2007. Structured Models for Fine-to-Coarse Sentiment Analysis. ACL

18. McDonald Ryan, Kerry Hannan Tyler Neylon MikeWells Jeff Reynar. 2007. Structured Models for Fine-to-Coarse Sentiment Analysis. ACL

19. Pang Bo, and Lillian Lee. 2008. Foundations and Trends in Information Retrieval 2, vol. 1-2, pp. 1–135.

20. Pang Bo, and Lillian Lee. 2008. Foundations and Trends in Information Retrieval 2, vol. 1-2, pp. 1–135.

21. Searle, John R. "A Taxonomy of Illocutionary Acts", in: Günderson, K. (ed.), Language, Mind, and Knowledge, Minneapolis, vol. 7. 1975

22. Searle, John R. and Daniel Vanderveken. Foundations of Illocutionary Logic. Cambridge University Press. 1985. ISBN 0-521-26324-7

23. Searle, John R. Expression and Meaning. Cambridge University Press. 1979 ISBN 0-521-22901-4

24. Searle, John R. Speech Acts. Cambridge University Press. 1969 ISBN 0-521-07184-4

25. Turney Peter D.2002. Thumbs Up or Thumbs Down? Semantic Orientation Applied to Unsupervised Classification of Reviews. ACL, pp. 417- 424.

26. Turney Peter D.2002. Thumbs Up or Thumbs Down? Semantic Orientation Applied to Unsupervised Classification of Reviews. ACL, pp. 417- 424.

27. Wilson Theresa, Janyce Wiebe, and Paul Hoffmann. 2005. Recognizing Contextual Polarity in Phrase-Level Sentiment Analysis. HLT/EMNLP 2005

28. Wilson Theresa, Janyce Wiebe, and Paul Hoffmann. 2005. Recognizing Contextual Polarity in Phrase-Level Sentiment Analysis. HLT/EMNLP 2005

29. Zhang Yu, Li Zhuoming, Ren Fuji and Kuroiwa Shingo. 2008. A preliminary research of Chinese emotion classification model. IJCSNS, 8(11),127-132.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

30. Zhang Yu, Li Zhuoming, Ren Fuji and Kuroiwa Shingo. 2008. A preliminary research of Chinese emotion classification model. IJCSNS, 8(11),127-132.

31. Аврорин В. А. Проблемы изучения функциональной стороны языка (К вопросу о предмете социолингвистики) / В. А. Аврорин. — Л., 1975. — 276 с.

32. Арутюнова Н. Д. Прагматика / Н. Д. Арутюнова // Лингвистический энциклопедический словарь. — М., 1997. — 698 с.

33. Бенвенист Э. Общая лингвистика / Э. Бенвенист. — М., 1974. — 447 с

34. Блумфильд Л. Язык / Л. Блумфильд; пер. с англ. — М., 1968. — 607 с.

35. Васильев И. А. Эмоции и мышление / И. А. Васильев, В. Л. Поплужный, О. К. Тихомиров. — М., 1980. — 192 с

36. Вежбицкая А.Семантические универсалии и описание языков: Грамматика. Семантика. Ключевые концепты культур. Сценарии поведения / Пер. с англ. А. Д. Шмелева; под ред. Т. В. Булыгиной. — М., 1999. — 777 с.

37. Виноградов В. В. Исследование по русской грамматике. Избранные труды / В. В. Виноградов. — М., 1975. — 312 с.

38. Вольф Е. М. Функциональная семантика: оценка, экспрессивность, мо- дальность / Е. М. Вольф. — М., 1996. — 168 с.

39. Выготский Л. С. Мышление и речь / Л. С. Выготский. — М.: Л., 1934. — 232 с.

40. Гальперин И. Р. Очерки по стилистике английского языка / И. Р. Гальперин. — М., 1958. — 457 с.

Article

Philosophy of ethnicity and religion the other national examples

By: Wright Judith, M.

USA, Lusiana University, Department of Colonialism and Elimination
judi@stanford.edu,uk

Abstract

This essay begins from a simple premise: determinations of 'Australianness' and 'the Australian character' have been and continue to be inextricably linked to the fetishisation and reification of space in popular cultural manifestations of Australia. This is evident throughout white Australian cultural histories, as well as white histories of Australian culture. Perhaps this is a tautological claim in relation to any conception of nation; tied as such conceptions are to modern practices of cartography and geography. However, it is my contention that whilst notions of space play a determinant role in general vis-à-vis the configuration of nation (and national character), they play a larger role than usual in the configuration of 'Australia'; the function of space in the conception of Australia is less modulated through competing discourses such as class, ethnicity and religion than in other national examples. This emphasis continues to privilege a mythical vision of space, with terra Australis incognita reified according to either of two dominant paradigms: the landscape is cultivated as a blank space offering the egalitarian opportunity for 'man' to reassess and reassert 'his' place in the natural order; or the landscape is cultivated as a sublime object—grand, and at times terrifying in its vastness and emptiness, a spectral antipodean environment that seems to 'naturally' lend itself to the gothic mode.

Keywords: colonialism, nationalism, national examples, Australia.

Introduction

The following essay analyses these representations of Australian space in two sections. The first section discusses the spatial fetish in Australian culture in pre- and

post-1788 European and Australian perceptions of terra Australis, through critical discussion of a selection of literary and cinematic artifacts. I follow a line of thought initially suggested by Ross Gibson in The Diminishing Paradise and later re-deployed by Peter Sloterdijk in In the World Interior of Capital that imagines cultural discourses about the antipodes and Australia as the product of a profound disappointment regarding the actuality of the Australian experience. In this reading, the terrestrialisation of the antipodean imaginary after invasion and colonisation—whether it be the optimism of the Patersonian bush-idyll, or the negative form signified by the Clarkeian gothic—has generated a diffuse sense of boredom that has lingered in cultural artifacts across multiple media to the present day. At the same time, this fetishisation of space—'bush', 'beach' or 'outback'—continues to mystify nineteenth-century history: the massacres of Aborigines, convict abuse, the Squattocracy, and so on.

I then argue in the second section that Justin Kurzel's recent horror thriller Snowtown, along with a handful of other Australian films, deliberately problematises this mythical representation of space in the bush-idyll and the Clarkeian gothic by depicting suburban space as the product of uneven geographical development; in Kurzel's film, space is gridded to the unproductive suburb, primed for the generation of violent, antisocial behaviour. Kurzel thereby aestheticises the argument of Gibson and Sloterdijk, demonstrating a socio-spatially-produced boredom with lethal consequences. Through its foregrounding of temporal cinematic effects, the film fetishises time and, in the context of its depiction of suburban marginality, reminds the viewer of the temporal dimension of political struggle as both unleashed through the unevenly urbanising forces of capital (Harvey 146-50) and repressed in the dominant depictions of space as either idyll or spectral landscape. Snowtown is thus a rare film in the Australian archive, suggesting Australia's spatial mythos obfuscates class exploitation, thereby challenging the myth of egalitarianism (linked to a perception of terra nullius, unbounded continental space) that continues to define much popular Australian discourse. On 28 June 1901, a 46-year-old French wood carver named Eugene N. was admitted to the London County Council's (LCC) Hanwell Asylum singing the Marseillaise at full throttle. In addition to boasting about his vocal talent and great riches, he repeatedly demanded to see the Queen, insisting it was his right as king. He was diagnosed with general paralysis of the insane (GPI), a disease associated with tertiary syphilis, which he had contracted as a young man. Scars believed to have been caused by syphilitic lesions were found on his body, confirming the diagnosis. According to his wife, who furnished the asylum authorities with details of her husband's history, Eugene had been 'a steady, temperate man, thoroughly moral, very industrious'. He had begun to suffer from dyspepsia and dilation of the stomach, poor eyesight, and 'sharp shooting pains in the legs' eight or nine years prior to admission. The 'extravagant ideas' had begun around six months before he arrived at

Hanwell. Just two months after admission, Eugene was reported to have been 'pale and emaciated, continually talking to imaginary persons, making lunges at the wall, or jerking his hands in the air as if throwing off some imaginary objects on his body'. He frequently rubbed the skin on his knees and feet, all the while muttering 'electricity'. In November, five months after he was admitted, Eugene died. A post-mortem examination confirmed that he was 'tabo-paretic', suffering from tabes dorsalis and GPI, both of which could present during the tertiary stage of syphilis.1

Eugene's 'case' was included in a study of tabes dorsalis conducted by London pathologist Frederick Mott and published in 1903. In it, Mott claimed, among other things, that it was not uncommon for tabo-paretic patients to suffer from persecutory delusions or hallucinations that related to their bodily pain, writing:

These patients often believe they are being tortured by unseen agencies, that electricity has been turned on by their enemies; they have been given poison which has gone into their legs and feet. They may associate the pains experienced with dreams or visual hallucinations; and they may tell you [...] that lions and wolves came and gnawed their limbs by night, and will beg you not to let them be tortured again. (*AoN2*, p. 44)

Mott was not the first to have commented on this phenomenon. In his dictionary entry on locomotor ataxy, another diagnostic label for tabes, the Physician Superintendent at Bethlem Royal Hospital, George Savage, wrote thatcthere may be insane interpretations of the ordinary crises [...]. One man may attribute the pains and weakness in his legs to poisoning, or to 'influence' — electricity or mesmerism; while another will say the pain and thickening about his ankles are due to diabolical possession, and that the bullae [...] are marks of the devil's grip.2

Mott believed that these accounts were illusions, defined as 'a false interpretation of a sensation actually perceived', rather than delusions which the eminent Scottish alienist Thomas Clouston described as 'a belief in something that would be incredible to people of the same class, education, or race as the person who expresses it, the belief persisting in spite of proof to the contrary'.3 Because reports in asylum case notes were recorded as 'delusions', I shall use this term. Technically speaking, however, I agree with Mott. I believe that these accounts were, indeed, illusions, that is, erroneous interpretations of painful and bewildering bodily sensations and the agencies that caused them. As such, they can be analysed as pain narratives. This article asks, therefore, what delusional themes can tell us about the subjective experience of pain in asylum patients with tertiary syphilis.

The historiography of syphilis is considerable but little work has been done on GPI and even less on tabes dorsalis.4 Substantive studies tend to focus on the more frequently diagnosed GPI.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Psychiatrist Edward Hare produced a lengthy essay on its epidemiology, attributing its sudden rise in Europe during the nineteenth century to the proliferation of 'a special neurotropic strain of the syphilitic virus'.5 Juliet Hurn's doctoral thesis charts medical attitudes towards GPI in Britain from 1830 to 1950.6 The most recent and by far the most comprehensive work has been produced by social historian Gayle Davis whose monograph *The Cruel Madness of Love* traces the evolution of GPI as a disease category in a changing social, moral, and medical climate in Scotland during the late nineteenth and early twentieth centuries.7

None of these studies addresses pain because GPI was, in itself, rarely painful. Yet, tabes dorsalis, which often preceded GPI or coexisted with it as tabo-paralysis, affected the nervous system causing agonizing pain in virtually any part of the body, but particularly the legs, viscera, and head. Indeed, the broader topic of somatic pain in nineteenth-century asylum patients has received very little attention from historians, which is surprising given the lamentable physical and mental condition of so many inmates.

By arguing that delusions relating to bodily sensations can be construed as pain narratives, this article will add to the growing number of voices, including those of literary scholar Lucy Bending and cultural historian Joanna Bourke, who refute the much quoted claim by Elaine Scarry (1985) that 'physical pain does not simply resist language but actively destroys it'.8 While pain narratives do exist in myriad forms — often fractured accounts in diaries, letters, case-books, and medical journals — the voice of the historical patient-in-pain, particularly the socially disadvantaged patient, remains elusive. Following his clarion call to 'do history from below' in 1985, Roy Porter drew attention to delusional writings in a number of publications, thus demonstrating their historical value and ability to provide insights into the preoccupations and subjective world of people deemed to be insane.9Porter was intrigued by 'mad writings', commenting that 'there is no more splendid cache of psychopathological material than the delusions recorded over the centuries by the insane'.10 In *The Madhouse of Language*, literary scholar Allan Ingram has produced a sophisticated analysis of the language of madness drawn from accounts produced by the so-called mad, as well as the 'sane', recorded in medical records and texts, and in more literary works. He analyses language within the framework of linguistic and medical discourses of the long eighteenth century to gain a deeper understanding of how today's critic or historian might understand the experience of madness. Drawing on the Lockean notion that madmen have wrong ideas but reason correctly, he writes that once the power of reason is granted, the articulations of madness can no longer be regarded as ravings or ramblings, but become available as linguistic acts to be read and understood within a system of grammar, and within a social system, just like any other.11

Ingram also connects language to the somatic experience of pain and, for this

reason, his work has been particularly useful.

Most historical work on delusions has focused on first-person narratives in edited volumes and anthologies. These include Dale Peterson's anthology (1982), as well as a number of interpretations of the writings of London tea merchant James Tilly Matthews (1770–1815) and the German judge Daniel Schreber (1842–1911).12 Clinician and historian Allan Beveridge has drawn on accounts of delusions to provide insights into the psychological preoccupations of individuals through his study of patients who were admitted to the Royal Edinburgh Asylum between 1873 and 1908.13 Beveridge referred to these letters as 'bulletins from the front line', which are 'less tidy, less polished productions than published works [which][…] arguably […] give a more authentic picture of the nature of mental illness a hundred years ago' ('Voices of the Mad', p. 907). I will be making a similar point in relation to records in asylum case notes.

Few social and cultural historians have, however, tapped the rich seam of delusional content that was recorded in asylum case notes. There are good reasons for this. Literary scholar Carol Berkenkotter has shown how shifting psychiatric epistemology shaped the construction of asylum case notes, while social historian Jonathan Andrews has drawn attention to the potential pitfalls around working with these accounts, particularly relating to issues of inconsistency, omission, bias, and censorship.14 Case notes were usually written by doctors who might have been informed by nursing staff, the patient's relatives, or the patient, all with his or her own interests. The degree to which notes provide an insight into clinical 'reality' is, therefore, questionable because each will have been subjected to at least one stage of interpretation before the historian adds her own layer of reflexive interpretation to 'the mix'. Because we are trying to get closer to the patient's subjective experiences, rather than to that of the doctor, I will focus on the meaning of delusional *themes*, such as electricity, rather than provide a close textual analysis of the delusional accounts. Such themes, which are replete with symbolism, can be understood within a similar framework to that used for analysing metaphors, which imbue delusions with meaning, both describing and constructing experiences.15 While we can never really know for sure whether anomalous sensations were the result of tabes or neurological damage caused by other factors, we can be reasonably sure of the GPI and/or tabes diagnosis because they were among the few, if not the only, conditions treated in mental institutions where lesions could be found at post-mortem.16

To summarize, this article sets out to ask what recorded delusions can tell historians about the subjective experience of pain in asylum patients with tabes dorsalis, thus exploring the complex relationship between culture, the body-in-pain, and the

disordered mind. In terms of the structure, I will provide a brief overview of syphilis and GPI/tabes, and their symptoms, followed by a methodology for understanding delusional themes, applying this approach to that of 'electricity'. Finally, I will suggest the meaning given to pain by patients, how it was constructed, and some of the psychosocial consequences of these interpretations. First, however, it is important to understand tertiary syphilis within its social and historical context at the end of the nineteenth century.

Syphilis, GPI, and Tabes Dorsalis

Painful, horribly disfiguring, and incurable, few diseases were as socially freighted or feared as syphilis in Victorian Britain. Particularly prevalent in men, especially those who had served in the army or navy, it was cloaked in shame and stigma. Often referred to as 'the secret disease' or 'a social evil', syphilis was associated with 'sin'. During the latter decades of the nineteenth century, around five to seven per cent of those infected with syphilis developed diseases of the tertiary stages, which usually manifested as GPI, tabes dorsalis, or tabo-paralysis.17 At the time, a significant number of 'alienists', as nineteenth-century psychiatrists were called, believed that GPI and tabes could be caused not only by syphilis but by other pernicious effects of modern life; these included excessive alcohol consumption, tobacco, sexual indulgence, and over-work. By the end of the century, with degeneracy theory in the ascendency, most — but not all — alienists believed the underlying cause of GPI/tabes to be a faulty heredity, activated by syphilis. The aetiological link between syphilis and GPI/tabes was not proven in the laboratory until the early twentieth century following a chain of discoveries that began with the identification of the *treponema pallidum* as the causative agent of syphilis in 1905. A year later the Wasserman test was introduced to detect the bacterium in the blood and, in 1907, in the cerebro-spinal fluid. In 1913, it was found in the brain of a patient who had died from GPI.18

Incidences of GPI and tabes were particularly high in urban areas, with London numbers exceeding those of anywhere else in England and Wales. In 1901, no fewer than 17 per cent of male asylum admissions to LCC Asylums were diagnosed with GPI, compared to 11 per cent across England and Wales in a similar period. Death rates were even higher. General paralysis accounted for 38.5 per cent of male deaths in LCC asylums compared to 27.4 per cent nationally in 1901. The socio-economic consequences were significant, with most deaths occurring in men aged 35 to 54 when many were at their most productive. The wealthy — and it was common in men from all social classes — could afford to be looked after at home or in a discreet private nursing establishment, thus evading the social stigma associated with asylums, as well as the statistics. Tabes and GPI were diagnosed far more infrequently in women: 3.3 per cent in London compared with 2.4 per cent nationally in 1901, although this percentage did begin to rise in the early twentieth century.19 Some contracted it through prostitution, others from their husbands.

Recording a diagnosis could be a vague and arbitrary affair. On admission, most patients with both tabetic as well as paretic symptoms were given a primary diagnosis of GPI, as in the case of Eugene N. As the disease progressed, tabetic symptoms might diminish while paralysis and dementia associated with GPI became more pronounced, ultimately leading to death. Mott circumvented the GPI/tabes distinction by using the term 'tabo-paralytic', claiming that many of the leading authorities on the subject believed that 'etiologically and pathogenetically the two diseases were identical'. He maintained that 'there is one tabes which may begin in the brain [...] or in the spinal cord [...] or in the peripheral nervous structures' connected with different parts of the body (*AoN2*, p. 3). By the 1920s, all forms of tertiary syphilis that affected the nervous system, including tabes dorsalis and GPI, were included within the umbrella category of neurosyphilis (Davis, p. 16). Not only was the prospect of an accurate diagnosis confused by myriad symptoms, it could also be influenced by a patient's social class due to the delicate nature of his condition. While county asylum patients were diagnosed with general paralysis, Mott wrote that 'when a noble or distinguished patient suffers from grandiose delusions and other signs of the progressive brain disease which in a few years will terminate fatally, it is given out that he is suffering from locomotor ataxy' (*AoN2*, p. 3). Whatever the diagnostic label, those suffering from these forms of tertiary syphilis faced an incommutable death sentence. Months or years of excruciating and debilitating pain in the case of those with tabes were often followed by the gradual deterioration of body and mind that required intensive nursing care in the GPI wards of a mental establishment.20

Not only did confusion around diagnostic categories prevail, so, too, did symptoms. Syphilis was often referred to as 'the great imitator' or 'great imposter' because it could so easily be confused with other conditions. Many sufferers believed for years that the pains in their legs were sciatica or rheumatism, or that they suffered from gout (*AoN2*, pp. 42–43). Indeed, it was not uncommon for tertiary syphilis to be diagnosed fifteen or twenty years after the initial infection, having remained latent in the body during the intervening period. In the case of tabes or tabo-paralysis, the syphilitic spirochaete caused degeneration and inflammation of the dorsal, or posterior, column of the spinal cord, giving rise to a number of symptoms. Mott enumerated the main ones as reflex pupil rigidity (Argyll Robertson pupils); lightning pains, absence of deep reflexes; visceral disturbances, bladder troubles, and gastric crises; motor disturbances; and mental disturbances (*AoN2*, p. 30). He wrote how patients with tabes dorsalis suffered from agonizing pain with pin-point pupils, citing the case of one woman for whom 'even the light of the windows was so painful she would bury her face in the pillow' (*AoN2*, pp. 31, 43). Abdominal or 'girdle pains'

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

were common, described by Mott as a 'tightness compared to an iron jacket or the constriction of a tight belt', and by one of his patients as if 'something was squeezing him in a vice' (*AoN2*, pp. 43, 122). Another patient experienced a burning pain in the larynx and felt he was going to be suffocated (*AoN2*, p. 57). A common early symptom of tabes was lancinating pains which Mott likened to 'stabbing, shooting, boring or lightning, or to hot wires thrust into the flesh' (*AoN2*, p. 42).

GPI tended to be associated with dementia and paralysis of virtually any part of the body. In itself, it does not cause pain. Even when pricked by a needle, GPI patients were reported to feel — or, at least, complain — very little due to the partial destruction of the cerebral cortex, which processes sensory information (*AoN2*, p. 312). However, while a patient may have been diagnosed with GPI, he may also have suffered from the painful symptoms of tabes, even at the advanced stages of the disease. Mott wrote that

> many of the tabetic cases of very old standing still suffer with the lightning pains and visceral crises. All the while there are any rootlets left undestroyed by the disease, pains may occur and radiate all through the sentient grey matter, each decaying fibre serving as a fulminating agent. (*AoN2*, p. 79)

Not all tabetic patients developed GPI and its associated mental symptoms, which invariably resulted in admission to an asylum. Patients who escaped this fate were usually As is so often the case with hallucinations and delusions, whatever their aetiology, those associated with the pain of tabes were frequently frightening, persecutory, and condemnatory. Mott cited the experiences of a male patient, referred to as F. W. R., who was a 35-year-old clerk, admitted to Claybury Asylum in 1899, believing two nurses were following him around, talking about him, turning on electricity, and pulling his legs at night. The patient reportedly associated the lightning pains and cramp-like spasms with the voices. He claimed one nurse caused him

> to have electric shocks in his limbs, body, and face. They pull his bowels about, and caused him to have pains at his heart; some time ago they continually put poison into his rice pudding, which burnt the inside of his stomach. (*AoN2*, pp. 82, 118–19)

Mott recounted another case of a musician who suffered from lightning pains and heard an orchestra which

> he associated with the electric wires and electric currents in his body [...] and being a professional flute player, he whistled very accurately the melody he heard in his mind, and was quite surprised that I did not hear it also. (*AoN2*, p. 83)

Another case was a dock labourer who was admitted to Claybury aged thirty-five having suffered for years from what he believed to be pains caused by rheumatism and indigestion. 'After three years he had delusions of persecution, that unseen agencies turned on electricity and blew up his stomach', Mott wrote (*AoN2*, p. 56). In 1901, Elizabeth H, a 51-year-old woman, was admitted to Hanwell tied to a stretcher and in a maniacal state with conjugal paral-

ysis. She claimed to 'see Old Nick' and that 'Burglars came into the house, they boiled the pot and then poured it down her throat' (*AoN2*, pp. 242–43). Her case notes record that she believed her 'arms, knees & legs are diseased and that she has the "black pox"'.21 George Savage explained how one patient would claim that his bowels had been twisted by his persecutors, while another stated that red hot irons had been thrust into his feet and eyes. Other tabetic patients have been recorded as saying that worms were eating their insides out, that lions wanted to devour them, or that snakes were living inside them. These delusions clearly signified extreme psychic distress as well as physical pain. Sufferers were in the grip of an existential crisis as they grappled with the symptoms of a painful and socially stigmatized disease that would almost certainly end in an ignominious asylum death. The next section looks, therefore, at how recorded delusions might provide us with deeper insights into the patients' experience of bodily pain.

Delusions and their Meanings

What, then, can delusional themes tell us about the meaning given to pain by tabetic patients? First, we know that the experience of pain is formed by the embodied consciousness and theories of the body and mind in any given culture at any given period of time.22 'The subjective character of experience (its phenomenological content)', Joanna Bourke has written, 'does not simply arise from interactions in the world but is constituted by those interactions' (*Pain and the Politics of Sympathy*, p. 14). People's experiences of their bodies are shaped by a range of cultural and societal influences from 'language and dialect, power relations, gender, class and cultural expectations, climate, and the weight and meaning given to religious, scientific and other knowledges' (*Pain and the Politics of Sympathy*, p. 18).

In his ground-breaking book, *The Illness Narratives*, cultural anthropologist and psychiatrist Arthur Kleinman states that 'cultural meanings mark the sick person, stamping him or her with significance often unwanted and neither easily warded off nor coped with. The mark may be either stigma or social death.' He adds: 'The cultural meanings of illness shape suffering as a distinctive moral or spiritual form of distress.'23So, whether or not somatic pain is triggered by a physiological event, such as a lesion caused by disease or injury, the experience is constructed in a complex web of social, cultural, psychological, and physiological interactions. 'Even when suffering, people adhere to societal norms, rituals, and stories', explains Bourke (*Pain and the Politics of Sympathy*, p. 6). This is where metaphors play such an important role. Making conceptually elusive physical sensations, such as pain, more psychologically tangible enables individuals both to understand their subjective experiences within their own terms and to communicate them.24 Metaphors expand the systems of knowledge and belief from which they evolve, creating new meanings and experiences. For example, new findings in the

field of bacteriology in the late nineteenth century gave rise to metaphors relating to the 'invasion' of the body by recently discovered pathogens. War metaphors became common in the early twentieth century. Salvarsan, the first chemical treatment for syphilis, discovered in 1909, was referred to as a 'magic bullet' (Brandt, p. 40).

Like metaphors, delusions are culturally constructed in terms of both their form and their content.25 The psychologist Brendan A. Maher hypothesized in 1974 that 'many paranoid patients suffer not from a thinking disorder but from a perceptual disorder' and that in the case of experiencing an unusual bodily sensation 'the patient is not presenting a delusion in any technical sense. He is describing an experience.'26 Maher continued: 'A delusion is a hypothesis designed to explain unusual perceptual phenomena and developed through the operation of normal cognitive processes' (Maher, p. 103). This takes us closer to the notion that somatic delusions can be misperceptions of bodily sensations. Broadly speaking, Mott and his late nineteenth-century colleagues were saying the same thing. Tabetic patients encountering the unannounced, the abrupt, the short sharp shocks, and the long sharp shocks of tabes dorsalis created narratives that were intended to be literal descriptions, yet were imbued with metaphor that helped them to make sense of their pain, thus shaping their phenomenological experience.27 Attributing painful sensations to electric currents, the work of devils, or attacks by wild and untamed animals transformed bewildering and frightening sensations into experiences that could, as Bourke has contended, be understood by the patient within his or her world view. This is not to say that this process enabled the patient to control their pains, even though they tried to by lashing out at the imagined attacker. But it did help them to understand them better, to comprehend that they could *not* restrain or manipulate these forces because, like electricity, devils, and wild animals, they were beyond human control. In his study of 'mad writings', Ingram has written that to find meaning in their pain, pain sufferers might develop a language that will allow them to 'negotiate' it (Ingram, p. 106). Maher commented that

> when a coherent explanation is ultimately developed, it should be accompanied by a strong feeling of personal relief [...] even if the explanation is [...] threatening to the patient: the kind of relief associated with 'Now I know the worst,' may temper the ominous implications of the explanation itself. (Maher, p.104)

There is a crucial distinction between how those with and without delusions respond to metaphorical associations. This lies in the system of belief surrounding them. The person who is not experiencing delusions consciously employs metaphor as a linguistic device to describe and give meaning to a sensation; the individual with delusions describes — and might act on — what he or she *believes* to be a real event. Asylum superintendent W. Julius Mickle, who wrote extensively on GPI, described one patient who,

> when walking quite alone, and when absolutely unmeddled with, was accus-

tomed to shriek suddenly at times, and when questioned on the subject declare that someone had that moment kicked or injured him, or that his back was broken.28

This draws attention to another difference between delusional and non-delusional narratives of pain. Tabetic patients with delusions provide an insight into somatic pain *as they were experiencing it*, rather than after the event.29 The French novelist Alphonse Daudet (1840–1897), who suffered from tabes dorsalis without mental symptoms, made extravagant use of metaphor in his notebook *La Doulou* where he described in detail his excruciating pains.30 He wrote that 'words come only when everything is over, when things have calmed down. They refer only to memory, and are either powerless or untruthful' (Daudet, p. 15). Ingram reinforces this point: 'The here and now is [...] a vital ingredient of this kind of mad language. Madness is in a perpetual present, and makes of the past only what can contribute to the chosen explanation for the reality of pain' (Ingram, p. 117). Delusions that are triggered by somatic sensations do, therefore, provide narratives of pain that are not self-consciously mediated by the sufferer, providing deeper insights into direct experiences.

Interpretation

Understanding the subjective meaning patients gave to their pain experiences requires a deeper exploration into why particular themes gained traction and agency within delusional systems. An obvious starting point for embarking on an interpretative analysis of the delusional themes is, therefore, to briefly outline prevailing cultural attitudes in Britain towards syphilis. Primary stage symptoms include painful ulcers and chancres, particularly on the genitals, as well as boils and buboes filled with foul-smelling pus. Unsurprisingly, biblical tropes abounded. As did references to other stigmatized diseases such as plague, which was associated with transmission by rats and fleas, and, in turn, with filth and defilement. In March 1891, a *Daily Telegraph* editorial famously commented on the one and only performance of the first British production of 'Ghosts', in which the Norwegian playwright Henrik Ibsen confronted social attitudes towards syphilis. The review was excoriating, describing the play as 'an open drain; a loathsome sore unbandaged; of a dirty act done publicly; or of a lazar-house with all its doors and windows open'.31

Syphilis had, therefore, become a powerful metaphor in itself. Historian Lesley A. Hall has suggested that by the end of the century 'the "guilty" sufferer [...] was more often perceived as male, conveying disease to his innocent family, as opposed to a contaminated prostitute infecting healthy young male bodies' (Hall, p. 123). Similarities between the social meaning and clinical manifestation of AIDS and syphilis have received a great deal of attention from scholars across disciplines. Susan Sontag's essay, 'AIDS and its Metaphors', is among the most notable. Here, she explains how,

historically, epidemics such as plague were often believed to be inflicted by God as a punishment, writing: 'Thinking of syphilis as a punishment for an individual's transgression was for a long time, virtually until the disease became easily curable, not really distinct from regarding it as retribution for the licentiousness of a community.'32 Parallels were drawn, both implicitly and explicitly, between the syphilitic spirochaete infecting the body and the notion of a social pathology in which the carriers of syphilis contaminated society. Gayle Davis has noted how one paretic patient in a Scottish asylum would stay clear of other patients lest he might infect them with syphilis, commenting how 'a number of those patients who knew or at least believed themselves to be venereally infected were said in their case notes to feel similarly dirty and infectious' (Davis, pp. 101–02). This explains the alienating effect of syphilis, which, in the tertiary stages, conflated social with mental isolation as patients descended towards madness and death, ministered to by asylum 'alienists'.

Returning to the punishment theme, the notion of 'pain as torture' has commonly been evoked by pain sufferers, whatever the cause of their pain and whether or not they were psychotic. Tabetic patients were no exception. Mott remarked on how the insane tabetic might believe that 'enemies are torturing them with electricity', or with 'hot irons and pincers before electricity was in general use' (*AoN2*, p. 37). Hot irons and pincers did, therefore, retain their symbolic value as instruments of torture, even though the practice had been outlawed in England more than two centuries earlier. Yet, as in the case of patient F.W.R., who believed nurses were turning electricity on in his legs, clinical staff were not always seen as benign. Indeed, it is possible that the notion of pain-as-punishment was psychologically appropriated by patients because hot irons had been used by physicians to cauterize syphilitic chancres in an agonizing and invasive procedure (Quétel, p. 117). Other potentially punitive 'treatments' included mercury, which could make symptoms worse and result in a number of unpleasant and painful side effects.33 Cultural historian Judith Walkowitz has pointed out that 'despite the new humanitarian spirit in medical practice [...] mercury application was very painful, it remained an appropriately punitive method of treating syphilitics'. She suggests that treatments may have continued after the subsidence of the symptoms to discourage the sufferer from 'further immoral activities' (Walkowitz, p. 55). Indeed, American actuarial tables from the early twentieth century show that the mortality rates of people who were untreated for syphilis was lower than those who had been treated with mercury.34 Other medical interventions that could have led to misinterpretations of bodily sensations were sensory tests in which patients were pricked with needles or subjected to electrical currents to see whether or not they would respond to pain (*AoN2*, p. 243). It is no wonder, then, that delusions of persecution implied a threat of attack from an agency that worked either directly on the body, such as electricity, or that was inflicted by

an external force, be it a doctor, a nurse, or the devil.

Electricity was a common delusional theme expressed by asylum patients suffering from a range of mental and physical conditions, including tabes and tabo-paralysis. From the latter decades of the eighteenth century and during the course of the nineteenth century, electricity gained increasing purchase on descriptive language and delusional themes. From the late-Georgian era, it was used to describe the body's biomechanical systems, as well as somatic sensations. Similarities between physiology and electrical events began to be investigated, and experiments in electrophysiology were conducted.35 Wider curiosity among a lay readership was piqued in 1818 by the publication of the highly popular novel *Frankenstein*, in which the author Mary Shelley 'shocked' her creature into life using the force of electricity. As a discipline, neurology emerged during the second half of the nineteenth century in tandem with the growing understanding and application of electricity brought about by the Second Industrial Revolution. Not only did electricity provide a fertile source from which new metaphors — 'current', 'shock', 'spark', 'pole', 'circuit', 'plug', 'energy', etc. — could be created, enabling experiences and events to be conceptualized differently, but it shaped ways in which the body was understood. Cultural historian David Nye has written how during the nineteenth century 'Americans internalized a new psychology in which the human personality was an electrical system that could be "switched on", "overloaded", "short-circuited", "shocked" and "burned out"'.36

Electricity was also valued for its therapeutic benefits. From the 1830s, galvanism was used to stimulate the nervous system — calming, stimulating, ameliorating pain, and producing contractions.37 Gout, rheumatism, sexual and urinary dysfunctions, as well as neuralgia and neurasthenia, were all considered treatable by this new technology. Newspapers and periodicals ran advertisements promoting electric belts for men and corsets for women, associating it with life and virility — force, energy, and strength.38 But there was also a dark side to electricity. Few people understood how it worked and for many it was silent, undetectable, and potentially deadly. Furthermore, it gradually began to be incorporated into the structures of a growing number of public and domestic buildings, including asylums. Fears around its dangers were stoked by the gas industry seeking to quash the competition.39 People believed that, like gas, electricity would explode (Gooday, p. 72). In 1881, Irish labourers laying electric cables in New York were terrified of 'the devils in the wires'.40 Yet these fears were not commensurate with the actual number of electrical fatalities, which were rare. When they did occur, the press had a habit of sensationalizing them.41

Perhaps nothing aroused fears around electricity more than reports of the first execution by electricity that took place in New York in August 1890. William

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Kemmler faced the chair for killing his lover, Lillie Zeiger, under the influence of alcohol. Both Zeiger and Kemmler had been married and were referred to as 'the guilty couple', implying that Kemmler was paying the price not only for murder but for adultery, sexual incontinence, and drunkenness, behaviours that were, incidentally, believed to cause syphilis during that period. The British press had a field day. Headlines such as 'The First Electric Execution. Terrible Scenes' or 'The Electric Death' enticed readers into reports of 'contortions of the body', 'frothing at the mouth', and 'a sickening smell of burning flesh and hair'.42

Electricity could, therefore, be perceived in a positive or a negative light. This, as cultural critic Tim Armstrong has explained, created a duality in attitudes to electricity as both a life force and a killing instrument, in addition to being 'part of the emerging technologies of medical control' that provided a '"clean" way of solving the problem of transgressive behaviour' (Armstrong, pp. 14, 32). Electrocution created 'a chastisement of the body which silently and invisibly absorbs the individual into a scientific and technological system', he has argued (Armstrong, p. 34). Electricity is a fatal and silent force: sterile, sterilizing, cauterizing, invisible, causing death without warning.

An analogy can be drawn between popular perceptions (and misperceptions) of the properties of electricity and syphilis, both of which exist or are able to exist in the body undetected. Some patients who developed GPI or tabes may have been surprised to discover that a syphilitic infection had remained in their system years after the primary symptoms had disappeared. Others would have been fully aware that they ran the risk of developing tertiary symptoms when the spirochaete might attack the brain, the nervous system or both, suddenly and unannounced. The lancinating pains that shot through the limbs were often described as 'lightning' pains; like electrical charges flashing through the sky, they were imbued with their own sense of agency or believed to have been sent as a punishment from God.

When these attacks took place, Mickle commented that male tabetic patients would 'shriek' with pain, a word described in 1911 as 'shrill & usu. inarticulate cry of terror, pain, &c., screech, scream; laugh uncontrollably [...] say in shrill agonized tones'.43 This, of course, was Mickle's term, and one he used frequently, which gives insight into his own perception of the experience and response to pain in male patients.44 'Shrieking' in this context implies surprise, shock, an unexpected and frightening event, or 'hysterical' which suggests a female quality. Did this mean that men with tabes and tabo-paralysis felt emasculated by their condition? Mickle commented that the gait of one patient who had previously been in the army had become 'slouching and unsoldierly' (Mickle, p. 62). Daudet commented that his 'resort to anaesthetics is like a cry for help, the squeal of a woman before danger actually strikes' (Daudet, p. 9). Lucy Bending has interpreted this as evidence of a 'kind of failure of masculinity' ('Approximation', p. 133). Indeed, in an era when independence

was valorized, the sight of other patients growing increasingly demented, paralysed, and helpless must have caused great anguish in men who had recently been admitted to paralysis wards and were still able to perceive their surroundings. It was a far cry from the hubristic delusions of grandeur many had manifested during their admission to the asylum.

Conclusion

This article is predicated on the premise that, in some cases of tabes dorsalis, delusions were misperceptions of bodily sensations and can be analysed by historians as pain narratives, thus providing insights into patients' subjective experiences. In particular, it draws attention to the degree to which somatic and psychic pain are inextricably intertwined, their boundaries hazy and porous. As Mott wrote: 'In taboparalysis, in the early stages, there may be an intensification of the pains and sufferings by the subjective attitude of the individual towards the effects produced by the irritation and degeneration of the sensory, somatic, and visceral neurons' (*AoN2*, p. 312). As the patient finds himself subsumed by an existential crisis of cataclysmic proportions, helplessly and hopelessly 'battling' society's most stigmatized disease, knowing, as far as he is able, that an ignominious and undignified death awaits him, his sense of shame and alienation, in every sense of the word, permeates these fractured pain narratives.

Here, I have drawn on delusions experienced by a small sample of asylum patients who were in the last stages of their life. They were mainly male, living in London *circa* 1900, and witnessing a period of massive change: faith in new powers (science and industry) was challenging old beliefs (God and religion); and when newly identified pathogens became the enemy, purity movements were mobilized to fight them on all fronts. If these delusional themes are compared with those experienced by other patients suffering from the same pathology and symptoms in another time period or culture, we would be confronted with a different pattern of themes and, thereby, experiences of pain. This is a bigger project consciously created to describe a physiological event, sometimes for the sake of posterity when used in a personal diary or journal. Even though they shaped experiences, the writer understood them for what they were, linguistic devices, and did not believe them literally to be true. Delusions were intended to be descriptions of real events; they were constructed out of metaphors to help patients make sense of and even negotiate their pain. Tabetic patients were existentially, psychologically, and physically invested in their delusions, fighting for their life, the only group of asylum patients suffering from a known psychopathology with fatal consequences. Mott said as much himself when he wrote that the tabetic with delusional insanity [...] probably suffers more than the sane tabetic, as he is not only tortured with physical pain, but also with delusions of persecution by unseen agencies — the true

pains forming a realistic basis to the delusions around which his whole psychical existence may centre. (*AoN2*, p. 44)

'Pain', according to clinician and literary scholar David Biro, 'is an all-consuming internal experience that threatens to destroy everything except itself — family, friends, language, the world, one's thoughts, and ultimately even one's self.'45 Through their delusional systems, asylum patients attempted to give meaning to their pain, transforming it into a tangible entity they could fight, or starve, or stifle. And this allowed them to cling to their sense of self for as long as possible — to challenge, to resist, to battle on before the *treponema pallidum* did its worst, rendering them totally helpless.

Endnotes

My thanks to the Wellcome Trust for supporting the Birkbeck Pain Project as well as to Joanna Bourke, Carmen Mangion, Daniel Goldberg, Melissa Score, and the anonymous reviewer for their valuable comments.

These details have been extrapolated from two sources. The first is Frederick Walter Mott, 'Tabes in Asylum and Hospital Practice', *Archives of Neurology from the Pathological Laboratory of the London County Asylums, Claybury, Essex*, 2 (1903), 1–327, (pp. 150–51). Further references to this volume will appear as *AoN2* after quotations in the text. The second source is Hanwell Asylum, Male Case Book 20, case 10,532, ff. 573–74, London Metropolitan Archives (LMA), H11/HLL/B/20/029. Where possible, I have compared Mott's notes with the asylum case notes for individual patients, quoting the latter where discrepancies exist between the two.

2. 'Bullae' are bed-sores. Geo. H. Savage, 'Locomotor Ataxy, Tabes Dorsalis, Ataxie Locomotrice Progressive', in *A Dictionary of Psychological Medicine*, ed. by D. Hack Tuke, 2 vols (Philadelphia: Blakiston, 1892), II, 750, bold in original.

3. 'Illusion', in *A Dictionary of Psychological Medicine*, I, 675; T. S. Clouston, *Clinical Lectures on Mental Diseases*, 3rd edn (London: Churchill, 1892), p. 244.

4. Key texts include: Peter Lewis Allen, *The Wages of Sin: Sex and Disease, Past and Present* (Chicago: University of Chicago Press, 2000); Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880 with a New Chapter on AIDS* (Oxford: Oxford University Press, 1987); *Sex, Sin and Suffering: Venereal Disease and European Society since 1870*, ed. by Roger Davidson and Lesley A. Hall (London: Routledge, 2001); John Parascandola, *Sex, Sin and Science: A History of Syphilis in America* (Westport, CT: Praeger, 2008); and Claude Quétel, *History of Syphilis*, trans. by Judith Braddock and Brian Pike (London: Polity Press, 1990).

5. E. H. Hare, 'The Origin and Spread of Dementia Paralytica', *Journal of Mental Science*, 105 (1959), 594–626 (p. 595).

6. Juliet D. Hurn, 'The History of General Paralysis of the Insane in Britain, 1830 to 1950' (unpublished doctoral thesis, University of London, 1998).

7.

Gayle Davis, *'The Cruel Madness of Love': Sex, Syphilis and Psychiatry in Scotland, 1880–1930* (Amsterdam: Rodopi, 2008).

8. Lucy Bending, 'Approximation, Suggestion, and Analogy: Translating Pain into Language', *Yearbook of English Studies*, 36 (2006), 131–37; *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford: Clarendon Press, 2000); Joanna Bourke, *Pain and the Politics of Sympathy, Historical Reflections, 1760s to 1960s* (Utrecht: Universiteit Utrecht, 2011); Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), p. 4.

9. Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98.

10. *The Faber Book of Madness*, ed. by Roy Porter (London: Faber and Faber, 1991), p. 131. See also by Porter: *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Penguin 1990), ch. 5; *A Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1987); and John Haslam, *Illustrations of Madness*, intr. by Roy Porter (London: Routledge, 1988).

11. Allan Ingram, *The Madhouse of Language: Writing and Reading Madness in the Eighteenth Century* (London: Routledge, 1991), pp. 6–8.

12. *A Mad People's History of Madness*, ed. by Dale Peterson (Pittsburgh: University of Pittsburgh Press, 1982); Mike Jay, *The Air Loom Gang: The Strange and True Story of James Tilly Matthews and his Visionary Madness* (London: Bantam, 2003); Eric L. Santner, *My Own Private Germany: Daniel Paul Schreber's Secret History of Modernity* (Princeton: Princeton University Press, 1996).

13. Allan Beveridge, 'Voices of the Mad: Patients' Letters from the Royal Edinburgh Asylum, 1873–1908', *Psychological Medicine*, 27 (1997), 899–908; see also 'Metaphors of Madness: Iain Crichton Smith's Journey through the Inferno', *History of Psychiatry*, 7 (1996), 375–95.

14. Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia: University of South Carolina Press, 2008); Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at the Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11 (1998), 255–81 (p. 280). See also Guenter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5 (1992), 183–205.

15. This draws on the ground-breaking work by George Lakoff and Mark Johnson, *Metaphors We Live By* (Chicago: University of Chicago Press, 1980).

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

16. There is, of course, also the possibility that their pains were caused by other physical diseases such as tuberculosis, or that they were suffering from psychogenic pain. It is not unusual to find descriptions of tabetic pain described in non-delusional terms, usually at early stages of the disease.

17. The actual percentage of men with syphilis who went on to develop diseases associated with its tertiary stage is difficult to ascertain. Julian Barnes has suggested that it was five to seven per cent. Alphonse Daudet, *In the Land of Pain*, ed. and trans. by Julian Barnes (New York: Knopf, 2002), p. 82.

18. Davis, p. 203. GPI was identified following the discovery of cerebral lesions by the French physician Antoine-Laurent-Jesse Bayle in 1822. By the 1860s, it had been accepted as a distinct disease within its own right with an 'identifiable brain pathology, predictable clinical history and a definite correlation between these two elements' (Davis, pp. 84–85). Tabes dorsalis — meaning wasting of the dorsal column of the spinal cord — was identified in the 1840s by the German neurologist Mauritz Romberg.

19. *LCC Thirteenth Annual Report*, 1902, p. 187, LMA; *Fifty-Sixth Report of the Commissioners in Lunacy to the Lord Chamberlain,* 1902, pp. 130, 152.

20. Most asylum patients died within two years of admission. Some lived far longer, while others went into remission and were discharged.

21. Patient details are drawn from the asylum case notes. Hanwell Asylum, Female Case Book 26, ff. 511–12, LMA, H11/HLL/B/19/049.

22. The Birkbeck Pain Project, 'Rhetorics of Pain: A Transcultural History of Bodily Pain from 1760–1960', in *Pain: Management, Expression, Interpretation*, ed. by Andrzej Dańczak and Nicola Lazenby (Oxford: Inter-Disciplinary Press, 2011), pp. 67–73 (p. 67).

23. Arthur Kleinman, *The Illness Narratives: Suffering, Healing & the Human Condition* (New York: Basic Books, 1988), p. 26.

24. Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies* (London: Sage, 1994), p. 55.

25.Richard P. Bentall, *Madness Explained: Psychosis and Human Nature*(London: Penguin, 2004), p. 130.

26. Brendan A. Maher, 'Delusional Thinking and Perceptual Disorder', *Journal of Individual Psychology*, 30 (1974), 98–113 (pp. 99, 102).

27. J. E. Rhodes and S. Jakes, 'The Contribution of Metaphor and Metonymy to Delusions', *Psychology and Psychotherapy: Theory, Research and Practice*, 77 (2004), 1–17 (p. 15).

28. Wm. Julius Mickle, *General Paralysis of the Insane*, 2nd edn (London: Lewis, 1886), p. 132.

29. Allan Ingram came to a similar conclusion, drawing on two case studies: one patient complained of violent pain in his stomach 'which arose from his navel string at his birth have been tied too short'; and a woman insisted that her insides were full of vermin and that it often felt as though 'they were crawling into her throat'. Ingram observes that both had generated an image that 'genuinely encapsulates the nature of their experience' (pp. 110–11).

30. These metaphors were remarkably similar to those found in delusions of tabetic patients: see Daudet.

31. *Daily Telegraph*, 14 March 1891, p. 5. Cited by Toril Moi, *Henrik Ibsen and the Birth of Modernism: Art, Theater, Philosophy* (Oxford: Oxford University Press, 2006), pp. 92–93.

32. Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors* (London: Penguin, 1991), p. 132.

33. Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1982), p. 53.

34. Cited by Walkowitz, p. 53; Louis Lasagna, *The VD Epidemic: How it Started, Where it's Going, and What to do about it* (Philadelphia: Temple University Press, 1975), pp. 67–68.

35. Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*(New York: Norton, 1999), p. 252.

36. David E. Nye, *Electrifying America: Social Meanings of a New Technology, 1880–1940* (Cambridge: MIT Press, 1990), p. 155.

37. Tim Armstrong, *Modernism, Technology, and the Body* (Cambridge: Cambridge University Press, 1998), p. 15.

38. Carolyn Marvin, *When Old Technologies were New: Thinking about Electric Communication in the Late Nineteenth Century (Oxford: Oxford University Press, 1988)*, p. 131.

39. Graeme Gooday, *Domesticating Electricity: Technology, Uncertainty and Gender, 1880–1914* (London: Pickering & Chatto, 2008), p. 65.

40. From a sketch by Walter Edison Kruesi, approved by Thomas Edison, Edison Pioneer Records, Henry Ford Museum Library, 1929, cited by Nye, p. 152.

41. Of the sixteen deaths occurring in Europe between 1880 and 1889, ten took place in Britain (Gooday, p. 66).

42. *The Morning Post*, 7 August 1890, p. 5; *Northern Echo*, 7 August 1890; 'Execution by Electricity', *North-Eastern Daily Gazette*, 7 August 1890, 4th edn.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Article

Historical memory and justice: historical responsibility for violence

By: Massumi Brian
USA, Illinois Univ. Department of Cultural Studies
massumi_brian@hotmail.com

Abstract

In the introduction to a recent book on historical memory and justice, Australian scholars Klaus Neumann and Janna Thompson write: 'It was once assumed that historical wrongs could be addressed and then forgotten. Few would make that assumption now' (5). The lesson of the reconciliation and justice commissions which, over the past two decades, have tackled problems of historical responsibility for violence—from Argentina to South Africa and from Spain to East Timor—is that committees of investigation, apologies and compensation funds do not close the ledger book of history. They may have very important and valuable outcomes, helping victims to recover from terrible past injuries, and enabling former enemies to live together. They may therefore be worth campaigning for with great energy. But they do not make the past go away. Some problems almost inevitably remain unresolved, and the tasks of remembrance, reconciliation and redress go on. This ongoing and global process of addressing the past is well illustrated by two recent events from opposite sides of the world.

In September 2015, thousands of Kenyans gathered in Nairobi's Uhuru Park to witness the unveiling of a bronze statue. This sculpture of a woman handing a pail of food to an independence fighter is a monument to tens of thousands of Mau Mau fighters, their supporters and other Kenyan civilians, who were tortured, killed or detained by the British colonial authorities during the fierce independence struggles of the late 1950s and early 1960s. The monument, a joint project between former colonised and former coloniser, was funded by the British government. It is part of the settlement arising from a 2013

court victory by 5,228 Kenyan victims of the violent suppression of the independence movement. The settlement also included a statement of 'profound regret' from the British government, who committed £19.9 million (around US$30 million) to a fund for the victims. It has been commonly assumed that nineteenth-century hospital patients were objectified, silenced, treated as the 'accident' of their disease, to use Michel Foucault's term, and also that as charity patients they were largely illiterate paupers, and consequently did not write accounts of their hospital experience. One such account has been known, however, since the 1970s, when W. B. Howie and S. A. B. Black published two articles in medical journals on Margaret Mathewson's 'Sketch of Eight Months a Patient, in the Royal Infirmary of Edinburgh, A.D. 1877'. Martin Goldman subsequently published excerpts from the 'Sketch' in *Lister Ward* (1987). But Mathewson's account of her experience as a surgical patient of Joseph Lister has never been published in its entirety, nor has it been known that the two existing copies of the manuscript differ extensively, as Mathewson decided to leave out 'some insignificant items and put in others more interesting' in the later version. Admitted because Lister thought he could save her arm from amputation by excision of her tuberculous shoulder joint, her narrative vividly details what it was like to be a surgical patient in Scotland in 1877. Her revisions to that narrative provide clues as to what she thought prudent to exclude from her account, after friends had asked her to publish it. As a charity patient, she was subordinated to the hospital staff, expected to wait uncomplainingly and to accept whatever treatment was given. But her 'Sketch' reveals such unexpected and surprising information as the willingness of the staff, including Lister himself, to teach her and other patients about the nature of their disease and also how to care for themselves, especially how to change their own dressings. Even more startling, Mathewson's narrative documents her confrontation of a 'cruel dresser', a medical student whom she believed to be deliberately causing her pain when he changed her dressing and manipulated her arm, and Lister's corroboration that the patient had the right to report such maltreatment. Mathewson's 'Sketch' narrates her progress from identification as an 'interesting' case to 'successful' and even 'favourite' case; and her movement from one subordinated to medical authority to one who speaks - and acts - on her own behalf.

Keywords: violence, responsibility, movement, treatment.

The 2015 agreement, which included a Japanese promise to pay into a fund to support surviving former 'comfort women', was hailed by some as an important step towards reconciliation. But the rather vague statements made by the two foreign ministers in December 2015 left huge questions

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

unanswered. It was unclear whether the Japanese government was even acknowledging the fact that 'comfort women' had been forcibly recruited, and subsequent statements by Foreign Ministry officials only served to further deepen the doubt (Morris-Suzuki). Rumours soon began to circulate that a precondition for the payments from the Japanese government was the removal of the 'comfort woman' statue outside the Japanese embassy: hence the presence of the young protestors, who mounted a non-stop 'guard' to prevent the disappearance of the statue (Kirk; Straits Times). What had started out looking like an act of reconciliation was by now starting to look—to some at least—more like an offer of hush-money, a payment for the creation of amnesia.

These stories highlight the profound dilemmas confronted in this special issue: conflicts over the memories and tangible scars left by wars, invasions and colonialism are a worldwide problem. Raising the spectre of international comparisons in the context of this history of violence may risk unleashing an ugly game of competitive self-justification: 'look, they are worse than us; we are not as bad as them'. But that is not, and must never be, the point. The point is that the wars and colonial violence of the nineteenth and twentieth centuries have left legacies of that injustice and violence which live on in many parts of the world. The task for those who try to address those legacies in diverse places is to learn from one another about ways to nurture redress and healing. He then dressed it with 'the Spray,' then put on chloride of zinc & moved the arm to & fro. The pain was indescribable. I never felt such excruciating pain before but often afterwards. I also felt the arm quite loose from my body [...]. Prof. then said to the students, '[...] I have a great fear of putrefaction setting in here & you all know the outcome. Thus I will look anxiously for the second day, or third day, between hope and fear. I hope the chloride of zinc will preserve it, but it is only an experiment'.1

Margaret Mathewson, twenty-eight-year-old daughter of a schoolteacher in Shetland, describes her tortuous post-operative experience after undergoing surgery for a tubercular shoulder joint performed by the well-known surgeon, Professor Joseph Lister. Her narrative account of her experience in the Infirmary vividly details what it was like to be a surgical patient in Scotland in the year 1877. Mathewson not only describes what her pain felt like, but the ardent evangelical faith that helped her endure that pain. In addition, in one startling section of the narrative she describes what she believes to be a medical student's deliberate infliction of unnecessary pain, and her own and Lister's responses to this. Her account of a nineteenth-century charity hospital patient's experience, written in her own words, not only provides invaluable insights into the Victorian hospital world 'from below', but ultimately projects a dramatic contrast to the Foucauldian image of the patient as objectified, silenced, and subordinated.2

Yet in the above quotation, Lister appears to treat his patient as an object lesson for his medical students, freely announcing

in front of the patient his fear that this particular 'experiment' might not work, and that if it did not, they all knew 'the outcome'. Indeed, Mathewson responded to Lister's words with a lengthy meditation on her 'hopes of eternity', as the 'Prof.' evidently had 'very poor hopes of my recovery' (S2, 46). Mathewson's description of this episode in her hospital history seems to amply confirm Michel Foucault's thesis in *The Birth of the Clinic* (1963) that hospital patients in the nineteenth century were objectified:

> in the clinic [...] one is dealing with diseases that happen to be afflicting this or that patient: what is present is the disease itself [...]. The patient is the accident of his disease, the transitory object that it happens to have seized upon.3

The sociologist Nicholas D. Jewson even more forcefully asserts this objectification of the nineteenth-century hospital patient in his now classic essay, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870'. In it, he claims 'Hospital Medicine' is that in which the 'sick-man' is 'unequivocally subordinated to the medical investigator', and 'designated a passive and uncritical role in the consultative relationship, his main function being to endure and to wait'.4 On these two foundational statements of the objectification, silencing, and subordination of the nineteenth-century hospital patient, other historians have elaborated further arguments that 'the patient's view' could not be directly accessed. David Armstrong, in 'The Patient's View', suggests that the patient's view is simply a 'precise technique' demanded by medical authority. The patient's pain, once the archetypal symptom, was assumed to be accessible to the doctor only through self-reflection on the doctor's own experience of pain. 'The patient's view and the doctor's view were shadows of each other.'5 Mary Fissell, in *Patients, Power, and the Poor in Eighteenth-Century Bristol*, documents the disappearance of the patient's language and individual interpretation of his or her medical history in the case-histories of the early nineteenth century as doctors increasingly employed medical jargon written for the benefit of colleagues. In Fissell's summary, 'patients were deskilled, denied interpretive authority', and 'their bodies made to speak for them'.6 But all such critical approaches to patient history, as Roy Porter charges, 'often end up by silently reinforcing that old stereotype of the sick, i.e. their basic invisibility.'7

This theoretical perspective on hospital patients in the nineteenth century has promoted the assumption that they did not speak or write about their experience for themselves. This may be why Mathewson's account has received relatively little attention, even though it has been known since the 1970s. Her 'Sketch' was first briefly described by W. B. Howie and S. A. B. Black in two articles published in medical journals.8 Martin Goldman, a science producer for BBC Radio Scotland, then put together a book, *Lister Ward*, which included excerpts from Mathewson's 'Sketch'

and some of her letters, along with poems and letters by William Ernest Henley, who had been a private patient of Lister's in the Edinburgh Royal Infirmary earlier in the 1870s. Although Goldman opens his book with the statement that 'this book is about what it was like to be a patient in a Victorian hospital, the Edinburgh Royal Infirmary, at the time when Joseph Lister was pioneering the use of antiseptics', signaling his interest in representing the patient's view rather than the conventional 'mellow haze of hero worship' in writings about Lister, he also sees the two individual stories of Henley and Mathewson as reflecting 'the universal experience of countless Victorian patients'.9 He does not regard the differences in their treatment as private, paying patient versus non-paying, charity patient as particularly significant. In his reading, both patients' accounts are 'biased': Henley's weakness is 'insincerity', or 'verses written for calculated effect rather than stating genuine feelings and responses to events'; while Mathewson's 'Sketch' is 'an evangelical tract [...] meant to convert people to hospitals and her brand of Methodism' that employs 'planted phrases' and 'planted sentiments' (Goldman, p. 147).

[3]

Still more recently Guenter B. Risse, in his history of hospitals as rooted in patient experience, *Mending Bodies, Saving Souls: A History of Hospitals*, discusses Mathewson's 'Sketch' at considerable length as his only example of a nineteenth-century account of hospital experience that is an actual 'eye-witness' account.10 However, he paraphrases most of the material he takes from Mathewson's account, thus presenting it largely from his perspective, not hers. In effect he repeats the process of silencing the patient by using his words, not those of the patient, to write her case-history as a medical historian understands it.11

Despite these acknowledgments of the existence of Mathewson's 'Sketch' of her eight months as a patient in the Royal Infirmary of Edinburgh in 1877, the unique significance of the narrative as a nineteenth-century charity hospital patient's account *in her own words* does not seem to have been recognized. The 'Sketch' has never been published in its entirety, nor has it been known that the two copies of the 'Sketch' held by the Shetland Museum and Archives differ extensively. The first, a photocopy of a complete holograph manuscript now in private ownership, is dated 8 August 1879.12 The second copy of the 'Sketch', a manuscript now held by the Shetland Archives, has only the first six pages in Mathewson's hand. The rest is a copy known to have been made by a friend of hers, Laurence Williamson. This copy is dated 27 September 1879, and in its 'Preface' Mathewson notes that 'in complying with the request of my friends to publish it I have written several copies having left out some insignificant items and put in others more interesting' (S1, 2). My comparison of the texts of these two versions of the 'Sketch' indicates that much of what Mathewson considered 'insignificant' in the earlier copy is highly significant for Foucauldian/Jewsonian readers, for it produces an image of a Victorian-era charity hospital patient strikingly different from

the passive, silenced 'body' we have been trained to expect.

By contrast, the excerpts published in *Lister Ward*, which are taken from the later manuscript, appear to invite a Foucauldian reading of Mathewson. Historian Hilary Marland, for example, comments that Mathewson 'seems to have no expectation of any power', and that this might be because she 'wishes to present a picture of Christian submission to her sufferings or, as Foucault and Jewson suggest, that she sees herself participating in a sort of unwritten contract' (Marland, p. 56). And indeed, Mathewson discovers on her first admission to the hospital that her position is that of an 'interesting case', a body on which the Professor lectures and medical students feel free to 'take lessons', a body over whose diagnosis and treatment she has no say. At one point in her narrative, she reminds herself that tho' its so far prison like, still it is not that, it is an Hospital, and tho' bleak and dreary looking I was there under the wise dispensation of God, and he will do with me just as he sees best. (S1, 26)

But a reading of both versions of the 'Sketch' in their entirety, and a careful consideration of the changes made in the later version, prompts a radical revision of Foucault's and Jewson's views on the objectification and powerlessness of the nineteenth-century hospital patient. I will quote Mathewson not only on what kinds of pain she endured, and how the staff responded to it, but how, in one extraordinary instance, she denounced what she believed to be deliberately 'cruel' treatment — only to tone down her description of the entire incident in the later version of the manuscript. Both versions of the 'Sketch', despite their numerous differences, produce a narrative of a hospital patient's progress from 'interesting' case to 'successful' and even 'favorite' case, a movement from one who is operated on to one who proudly describes to a doctor how she operated on herself, inserting a drainage tube in her own shoulder 'before a glass' (S1, 182; S2, 92). Finally when the two versions of the 'Sketch' are supplemented by some of the numerous letters written by Margaret and other members of her family, we discover important material about her methods of coping with pain even before she decided to seek admission to the Royal Infirmary of Edinburgh, as well as during her eight-month hospital stay.

'What's the best Professor's name for surgery?'

This is the question Mathewson boldly puts to the porter at the Edinburgh Royal Infirmary. It illustrates both her relative ignorance of surgical developments at this time and her active role in acquiring that knowledge and obtaining the best medical treatment available. It is particularly appropriate that her introduction to the Infirmary should begin, not with a question put to her by a member of the medical establishment, but with her own question, demonstrating her determination to find the best possible member of that establishment for

the treatment of her advanced and painful disease.

But who was Margaret Mathewson? Born in the schoolhouse in East Yell, Shetland on 18 April 1848, she was the eleventh child of a schoolteacher, Andrew Dishington Mathewson (1799–1887), and his wife, Barbara Robertson Mathewson (1807–1873). She grew up in that schoolhouse, helping with the farm-work as well as housework. She was educated solely by her father. She worked for various periods of time as a domestic in Edinburgh and Liverpool during the mid-1870s, but apparently returned home when she first developed 'chest disease' and then later pain and swelling in her shoulder.13 Before deciding to seek treatment at the Royal Infirmary of Edinburgh, she had been treated only by the local minister, James Barclay, as there were no doctors in Yell at this time. Barclay had learned what medical knowledge and skills he had from observing his father, who had been a doctor. But eventually Mathewson had decided she must travel to Edinburgh, as her arm kept getting worse, and she feared 'likely the disease was at the bone owing to the severe pain I always had in it' (S1, 1). She had arrived in Leith, the port of Edinburgh, where she had her 'usual boarding when South' two days previously after a lengthy voyage from Shetland (S1, 2). She had walked from the Edinburgh train station to the Infirmary, as she would meticulously document in the 'Sketch' she was to write two years later, on 'Fri morning Feb 23rd 10:30 AM', accompanied by Cousin Martha, or Mrs McTernan (S1, 2). Mathewson, like most of those who entered the Infirmary, was not a pauper. The *Medical Register* for the Royal Infirmary of Edinburgh in 1877 has a separate column for 'Paupers', but on the day of Mathewson's admission only two paupers were admitted: one a 'Labourer' and the other a 'Water Officer'. Occupations were listed for the other forty-eight patients, although the occupation given for female patients was usually that of the husband or father, such as 'schoolteacher' in Mathewson's case.14 They were nonetheless charity patients, treated and cared for without charge. Mathewson knew she had to have a letter of introduction in order to be considered for admission.

Though not a pauper, Mathewson clearly believed herself to be of much lower 'station' than the doctors. On the day she was admitted, she was first seen by William Watson Cheyne, who was Lister's house surgeon at the time, but later became almost as famous as Lister. She immediately recognized him as a 'Shetland gentleman', but he did not recognize her. However, after reading the introductory note from the minister Mr Barclay, the doctor seemed to recognize the minister's handwriting. 'He then looked at me, then read the note & again looked at me, and said Do you know me? Yes Sir. Who am I? Dr Cheyne of Fetlar Shetland Sir. Yes the same (Martha was surprised we were any ways acquaint [*sic*])' (S1, 3). Mathewson was obviously much pleased by the doctor's recognition, even if belated, and tickled by her cousin Martha's surprise that she was in any way 'acquaint' with him.15 Cheyne did a pre-

liminary examination of her shoulder and told her that it was not dislocated, but that she had an abscess in the joint and another on the collar-bone. He instructed her only to put on her outside jacket, as Prof. Lister would be in a hurry when he examined her.

When she first glimpsed Lister, passing him on his way into the operating theatre, she described him as 'an elderly looking gentleman' (SI, 4). After a rather disturbing interval during which she and Martha heard 'fearful screams' and then saw first a man carried out in a basket followed by his leg wrapped in silk paper, 'the blood tipping from it', she was introduced to Lister by Cheyne. Cheyne now called her 'an acquaintance of his from Shetland' (SI, 7). Mathewson comments in her 'Sketch' that Lister 'seemed to be a kind and good man' (SI, 7). Lister then examined Mathewson's shoulder again, enquiring into how long ago the trouble with the shoulder joint had begun. She answered, '12 months, Sir' (SI, 7). He also asked how the 'opening between the joints' had been made, and she answered that the Rev. Mr Barclay had made it a month ago. 'How did a minister make the operation?' Lister asked, and she replied that Mr Barclay was all the Practitioner there was in 'our island', a point confirmed by Cheyne (SI, 8).

What Mathewson did not tell Lister, however, was that in the absence of a 'Practitioner', and after Barclay's operation had been only partially successful, she had opened the joint herself. In an eight-page letter to her older brother Arthur dated 31 January 1877, she describes what had happened:

Now about my arm. Well I told you it was gathering & it continued to do so but was not like to burst (or even get Yellow & never did) thus I went to Mr Barclay on New Years day & he told me to call at Thos. Johnson's Reafirth & get a little Linseed meal for Poultices & use it till Wednesday following when he would call here. I did so but found the Poultices setting it backward. But Mr B came on Wednesday & opened it he got a lot of matter out then mixture. He also said the Poultices was set it back. The 3rd day after it gathered again & I opened it myself & got as much stuff again & I then made flour poultices & kept it open & a third time it gathered & I am still going on with poultices (now bread or loaf) & its issuing a very little yet & I find my shoulder is dislocated.16

Clearly, Mathewson had acted as her own surgeon when she felt that the minister's efforts were unsuccessful and even misguided. She not only opens the abscess — a process that must have been extremely painful but on which she does not enlarge — but she decides to use 'flour' poultices apparently made from bread. She does not, however, inform Lister about her surgical self-treatment.

Lister also asked her whether she had ever fallen on the shoulder (she had, in a hay loft), and what the marks on her chest were. They were marks from 'a drawing plaister', she replied, and when he asked

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

what that had been for, she replied, 'for chest disease Sir' (SI, 8). Lister then, Mathewson wrote, 'sat down folded his hands closed his eyes as if in silent prayer (which gave me more confidence in his skill and I also lifted my heart in prayer of thankfulness to God for directing me to this Christian gentleman)' (SI, 8). After this, he took a silver probe out of a case in his pocket. It was about four inches long, and he pushed it into her shoulder joint so that she could feel it 'quite into the shoulder cup' (SI, 8). The probing felt 'very sore' and made the shoulder bleed a little. Lister then asked her how long she had had 'chest disease', and she said, 'for about three years Sir' (SI, 9).

During the examination, Lister then turned to the students and said, Now gentlemen this quite accounts for the shoulder being diseased. The patient has had chest disease, and has suffered a great deal from it but now instead of falling deeper into the lung, it has very providentally [*sic*] turned off from the lungs into the shoulder joint had not this operation been made in the arm — it evidently would have returned to the lungs, and the patient would have died immediately. But this operation has drawn off a lot of discharge. (SI, 9)

In the earlier version of her 'Sketch', Mathewson includes in parentheses, 'this was just a repetition of Mr Barclays words when he made the operation' (SI, 9). In the later version, she omits this rather devastating comparison of the famous professor's medical opinion to the obscure minister's.

Following this examination and history-taking, Mathewson reports that Lister said, 'Well we will sound your chest some day and see what we can do for you' (SI, 9–10). This meant that she was to be admitted. Lister had decided that he might be able to help her by operating on her shoulder, as the disease had 'providentially' turned from the lungs into the shoulder joint. That tuberculosis was a systemic disease caused by a specific bacterium was not even imagined by doctors at this time (Robert Koch did not identify the tubercle bacillus until 1882). Lister's notion of 'germ theory' was still only partially based on Louis Pasteur's new theory of airborne microorganisms, despite his use of 'antisepsis' intended to destroy bacteria entering the body from the exterior and thus causing wound 'putrefaction'.17 But his admitting examination and questioning of the patient was as complete as his germ theory was incomplete: he tried to elicit full information from Mathewson about her medical history, her medical treatment so far, and her own opinion about her illness.18 That she did not tell him everything, and that his case notes — had he written any — would have differed from this patient's view, not only of her own case but of her surgeon's degree of expertise, he was, of course, unaware.19

'What like is your pain?'

On her first night in the hospital, Mathewson did not have much opportunity to see how well she could sleep in this 'strange scenery' with the pain in her arm, as she was awakened by the commotion of a railway accident patient being brought in (SI, 19). But on the second night, she fell asleep earlier than usual, only to wake at

around 11:40 p.m. At about midnight, she noted, Cheyne came in and checked on each patient as they slept. When he found Mathewson awake, he questioned 'Dear-o-me! How are you awake at this hour alone?'. When she explained that she had just woken up, the doctor asked 'Have you pain in your arm?' and 'what like is it?'. But when Mathewson replied that her pain 'wakens me out of sleep', and feels 'as if the arm was starting off', the doctor only replies, 'Yes so it is. O well I hope if you stay long with us you will get free of all your pain and good night' (SI, 19–20).

Pain medication was apparently not given preoperatively in any form in Lister's wards. Mathewson had to wait a full month in the hospital before her operation, probably because her arm continued to suppurate. Although she was allowed to walk about the ward freely, and to observe and talk to other patients, she does not describe any sort of pain medication being administered to herself or to other preoperative patients.20 Morphine was available in both oral and injectable form at this time, but Mathewson and patients in Lister's wards do not seem to have even been aware of its existence, or of any other pain-relieving agent except chloroform — and that was used only for major surgery. This was in contrast to other hospitals of the time: S. Weir Mitchell's work indicates that morphine was used freely to relieve the pain of war wounds in American hospitals.21 It was also in contrast to the apparently common use of opium in Britain to relieve the pain of those ill or dying with such diseases as tuberculosis at home.22

Mathewson describes, for example, the pain she observed in a woman with a twisted elbow joint whose hand has been 'put on the extension', which Mathewson carefully explains involves having increasing weights of sand attached to it by a cord and hung over the foot of the bed. After the weight of the sand has reached twenty-one pounds, the woman's hand and arm turn blue. Mathewson asks her if she feels much pain. The woman replies, 'Oh the pain is very bad', and asks if Mathewson can tell her why she is treated thus (SI, 44). Mathewson explains that the treatment is intended to 'stop the lower part of the arm from grating on the top part and to keep it in a proper position' until the operation can be performed (SI, 44). Yet the patient is not offered any medication, or Mathewson does not mention it.

Mathewson appeared not to regard pain as something she or anyone else was divinely ordained to suffer. As a convert to Wesleyan Methodism, she took very seriously her obligation to teach others about Jesus's ever available forgiveness and love, as well as to do anything she could to help them bear their pain. But she never spoke about pain as punishment imposed by a just but vengeful God, or as a special mission to bear Christ-like suffering. For the woman whose arm had been put 'on extension', and who turned out to be a 'Catholic' (Roman Catholic), Mathewson first explained to her that the reason she did not feel any better

even the second day after the operation was likely due to the effects of the chloroform, which would stay with her for some time after she had got over the operation, but then continued, 'I hope if you do not get better you will get home to heaven where theres no more pain' (S1, 46). When the woman exclaimed, 'Oh yes, Father will plead for me!', Mathewson insisted that she did not need Father O'Reilly; she did not need any priest except Jesus; that Jesus had suffered 'fearful pain' to prepare a place in heaven not only for the disciples but for 'every person as well which would believe he had suffered their punishment instead of them before God' (S1, 50–51).

Mathewson also stated that she did not believe in the doctrine of 'Election', at least not to the extent of believing that God '"elected" or ordained some to everlasting life, and some to everlasting death' (S1, 146). In Calvinist Scotland, many believed that pain and suffering in this life was an indication that they were doomed to everlasting pain and suffering in the next life. Mathewson's evangelical faith clearly led her to reject any idea that a profoundly loving and compassionate God could condemn human beings to everlasting punishment, and this belief also allowed her to feel that she could and should do anything possible to relieve her own pain and that of others — not only the mental torment of believing that one's pain was the consequence of guilt and sin, but the physical pain of the body as well. As she explained to a young doctor, she had never 'joined the teetotalism', thus she did not reject the use of alcohol, which happened to be about the only form of pain relief that was available on Lister's wards (S1, 189).

In a note written in pencil on 28 March, five days after the surgery, addressed to her brother Andrew and his wife Jane, Mathewson writes that the Professor had

moved the arm back & fore & up & down oh how sore it was I almost fainted so last night it was so painful I slept very little & am most have fainted 2 or 3 times as I was so weak I didn't know where at all I was & after a bit I ast the nurse for a teaspoon of brandy, but she was in bad temper after a little I ast a drink of water but no I got none until her time came the night nurses is the worst ones.23

It would appear that some nurses, but not all, were averse to providing patients with brandy. In a letter dated 12 April, almost three weeks after the surgery, Mathewson wrote in a letter to 'Dear Father Brother & Sister, etc.' that

Yesterday & last night I took bowel cramp, & was very ill but got little sympathy from those queer nurses & the head nurse Miss Logan was in another ward on duty there & none of this ones would give me a teaspoon of brandy or make me a cup of tea but laughed at me & by chance Miss Logan came & I ast her myself for a little brandy & told her for why. She went & gave me near a glass of brandy, which eased me instantly.24

After surgery, however, doctors appear to have routinely administered morphine orally to patients. Mathewson, like at least one other patient whom she describes, tried

to refuse the morphine, apparently believing it was an emetic or purgative.

Nurse kept feeding me with 'Ice' & asked if I felt much pain. Yes nurse a good deal. Would you please give me a little lemonade as I feel so hot. She brought it & sat down taking my pulse every ¼ an hour. As the night wore on the pain increased. I asked nurse for another pillow hoping I would not feel so giddy but it was all the same & feverishness increased & nurse observed me — restless & asked will you have a drink. Yes please nurse? she went for it was such a time away but was upstairs (as I supposed getting a draught from the Dr, came back with a medicine glass of murphey etc which I was resolved not to take but after some persuasion did take. Dr Cheyne came in about 12 p.m. and said well nurse how is the patients? Margt is very feverish & restless owing to a lot of pain [...] did Margt take the medicine? Yes Sir after some persuasion. How was that? Well, I believe she thought it was other medicine but as soon as she heard it was really for the pain she took it at once. Oh I thought she had a good reason for saying 'no,' but seeing she has taken this I can't give more at present. But give her plenty of 'Ice' mind Yes Sir. (S1, 70–71)

[8]

In the later version of the manuscript, Mathewson gives the correct name to the medicine, but seems to also feel she has to explain in greater detail her initial resistance to taking it:

As the night wore on, the pain increased, also the feverishness, and at times I was on the eve of shouting, the pain was so severe. I then thought 'I shall not shout as long as I can avoid it.' I thus hid my mouth in the sheet. I felt giddy and asked nurse for another pillow, and got it as I fancied I would not feel so sick. But it was the same. I felt so warm, I put down the quilt. Nurse said 'No you must not put off the quilt, but keep chewing ice and that will keep you cool, but would you have a drink.' 'Yes nurse please.'I thought now I would get a jug of cold water and I knew if I got hold of it I should take a drink. Nurse [...] then returned with a medicine glass of morphia, laudanum etc. She told me to take this quite up, and it would better me. I was not inclined to take it at all, as I had seen the effects of similar drafts on others that I was determined not to taste it if ever it came to me. She persuaded me, and told me 'It would ease the pain which you are trying to choke every now and then.' I took it quite out, when I heard it would ease the pain. (S2, 42–43)

When the doctor checks her, Mathewson's account in the later version has the doctor testifying to her willingness as a patient to do anything she was asked:

About 12 P.m. the doctor came in and said 'How are the patients?' 'Margaret is very feverish & restless and has a lot of pain [...]' 'Did she take the medicine?' 'Yes as soon as she heard it was for the pain, but ere then I thought she would not take a drop.' 'Dear-o-me how was that as I

thought she was nowise averse to anything we have wished her to do before at least? I have always found her so haven't you?' 'Yes I must say so too but I believe she thought it was some other kind of medicine as she told me she did not require it.' 'Oh, I thought she had a good reason for saying 'no.' Well, seeing she has taken it I can't give more at present, but give her plenty of Ice mind.' 'Yes sir.' (S2, 42–43)

Mathewson also describes the 'Catholic' patient as being unwilling to take the medicine offered her after surgery:

She continued very weak during the evening and seemed to get worse as the evening wore on. Dr Cheyne (our house Dr) came & took her pulse every half hour, and a special nurse was set at her bedside. Dr Cheyne came with a medicine glass full of morphia etc. and offered to her. She was very against taking it. He pressed on her to take it, and it would make her better. She did so after some persuasion.25

The day after the surgery, Lister came into the ward with a 'train of students' and asked whether she felt any pain. When she said she did, he asked 'What like is it? [*sic*] Is it an aching pain, or a severe pain, or starting pain? It is a squeezing pain Sir as if squeezing by a cord' (S1, 73). In the later manuscript, she enlarges on this questioning of the specific nature of her pain: '"What like is it? Is it a severe pain, an acute pain, an aching pain, or starting pain?" "It is neither sir. It is a squeezing pain, as if it was squeezed between two things or articles or with a cord, sir"' (S2, 42). In both versions of the 'Sketch', Lister accepts the patient's description of her pain as if it confirms his expectations, but he also supplies descriptors of pain, as if using the patient's pain experience as a diagnostic aid. In Mathewson's later version of the exchange, she gives herself the credit for coming up with the exact descriptor — 'squeezing' — as if she had more fully realized how important the precise character of the patient's pain was to the physician's diagnosis.

Then follows the first dressing change, during which Lister puts the arm through the full range of motions, causing the 'indescribable' and 'excruciating' pain as described in the opening quotation for this essay.26 In the later version of the 'Sketch', the dressing is followed by Lister using the opportunity to teach the students more about pain:

Prof. said to the students, 'Gentlemen the patient said to the Dr this morning on being asked if she had any pain, she said "I feel it sore but not painful." Now gentlemen, can you tell me what she meant?' 'She means that she wants a name for the pain Sir.' 'No she expressed herself exactly as she felt it at the time, and I am glad she did as it brings out a something I have been wishing to hear from some patient or another for some time back. Her expression is a Scotch phrase. An English person would have said quite the opposite — painful but not sore, but although I am an Englishman, I quite understand her. Have you not observed during the dressing how she tried to hide the pain by putting the sheet in her mouth? It shows me that she suffers a great deal more of pain than she wishes to let us know about and that is characteristic of

Scotch people. An English person would infer that she feels a great deal of less pain than she would wish to let us think she did, but she really does not. However, I have a great fear of putrefaction setting in. (S2, 45–46)

The rest of the paragraph follows as in the opening quotation. Here, Lister interprets her description of her pain as an indication of her national character: like 'Scotch' people in general, she is stoic and wishes not to let others know how much pain she suffers. It seems clear from Mathewson's description that she took considerable pride in his evident admiration for her stoic 'Scotch' courage. But her stoicism had its limits, as was soon to be demonstrated by her encounter with the 'cruel dresser'.

'I am determined to inform on you'

Soon after this episode, Lister (and Cheyne) left for London. Mathewson was left to the care of the new House Surgeon, Dr Roxburgh, whom she describes as being 'very kind to me' (S1, 107). But then there was a change of dressers (medical students who bound wounds), as every six months students were rotated for duty in the surgical or medical wards. Mathewson was then assigned to one of the new student dressers, a fateful change for her. 'Until then,' she wrote, 'I had not known experimentally what a "cruel dresser" meant' (S1, 107):

The first dressing Mr __ made I really thought he had overturned all the ligaments etc. which had then begun to go together. the pain was dreadful and the draw sheet & pillows etc had to be changed for the blood from the wound then the bandages was tight. Miss Logan came in and I was leaning on the table & crying from the pain & soreness. Dear-o-me have you got bad news. No Miss Logan, not in the way you mean, but I have got a cruel dresser!! (S1, 107–08)

She slept but little for the following two nights, and this was the case every time Mr __ (she never names him in either version of the 'Sketch') changed her dressings for the next three months.27 A letter to Mathewson's father dated 11 June 1877 demonstrates that, if anything, her description of the cruelty of this dresser is understated in the 'Sketch':

I mean to ask <thro the week> if they will let me go to the convalescent now, as then I would (I hope) get free of the fearful Squeezing Mr Hart gives me arm It couldn't be worse any way I think if it should'nt be much better. On Saturday he dressed me sitting on a chair (as I was up before he came, just to see if it would be any better being out of the bed) & it was worse than ever but I tried not to cry out much, he put his knee on my side below my arm and pulled up my arm with both hands the blood ran down over my clothes (thro the places where the tubes was in) it was very sore and painful all Saturday afternoon & night & I hardly sleep't any & it was still sore Yesterday morning but got a little better after that so as I sleept very well last night.28

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

At last, the dresser went on holiday to 'Vienna', and while he was away, Roxburgh again took over the dressing changes, for which she was 'thankful' (SI, 109).

But when Mr __ returned from his holidays, the torture of dressing days began again. She told herself that Mr __ was 'trying experiments' on her case and didn't really have a 'cruel design' (SI, 109). But then one day he asked her if she was not 'wearying to get away', and she replied

I am indeed. But your style of dressing is preventing my progress and prolonging my stay here. Well you know yours is a rare case and that's my chance for lessons," [*sic*] Well Sir Indeed, if you presume to dress me any longer so cruel, I am determined to inform on you, as I have that privilege if I choose, thus I am reminding you of that, so as to prepare you for your dismissal, Sir Do you really mean it Margt? I really mean what I say sir, as I have suffered too long for your pleasure & rather than to cause any gentleman lose so important a situation as you are preparing to fill. Well I am much obliged to you for this notice as I know you have it in your power to cause my dismissal, & I beg your pardon, & I shall not be so hard again If you don't inform this time yet. (SI, 109–10)

However, there was no difference in the way the student did her dressings thereafter, and when Lister returned from London to visit his patients in Edinburgh again, he was shocked by the condition of Mathewson's wound:

He came and began to undo the bandages on my arm when he came to the sore he stoped & asked whats been doing here (?) Who is the dresser? Mr __ Sir said Dr Rgh Well Mr __ you have not failed to move the joint here (Mr __'s face got red) and have reopened what was set together Sir which Im sorry for as I expected to see its great progression at this date. Then the pain it must have given the patient! (SI, 110)

Lister's reputation for rebuking students severely if he thought they had mistreated a patient is well known. M. Anne Crowther and Marguerite W. Dupree comment that 'his pained and public reproaches if dressers appeared at all careless or treated patients without proper consideration affected his supporters for the rest of their careers' (p. 102). Here Mathewson goes on to report the following conversation with Lister:

Dr did she never report Mr __ to you? 'Never to me Sir then said to me Did you always feel pain after the dressing? Yes Sir And did you always sleep well the following nights No Sir, I seldom slep't any the following two or three nights Sir. Just so, well do you think Mr __ did it from cruelty, or to cause you pain? No Sir, I think Mr __ did it so as I should not have a stiff joint afterwards, Sir. How do you think so? I think so Sir, as Mr __ told me I would be able to pull him around the bay near our place in Shetland, when he came there to spend his holiday yet someday perhaps Sir (a laugh.) very good proof, gentlemen, the patient understands the term 'a stiff joint.' Now Mr __ you see this young woman has not said a word against you to any person & surely you will treat her more gentle. (but

no it was the same next dressing day.) (S1, 110–11)

Lister's question as to whether Mathewson had ever reported Mr __ suggests that, if she had, the student would have been dismissed from the cherished post of dresser, just as she has stated in her account of her confrontation with the student. Even more significantly, this account suggests that Lister believes the student might have been deliberately sadistic, manipulating her arm as he did in order to cause her pain, just as Mathewson implies in her accusation that she is suffering for his 'pleasure'. Certainly both medical students and practitioners have been accused of sadism throughout medical history, but that charity patients would be encouraged to report a sadistic dresser and that this might result in the dresser being dismissed is a development unexpected at this point in nineteenth-century hospital history.29

Mathewson's version of the 'cruel dresser' story is significantly different in the manuscript dated 29 September 1879, however. It appears to have been carefully edited not only to improve the writing stylistically but to represent Mathewson's behaviour as literally more 'cautious'. She describes both her new dresser's treatment and her response to it in more succinct and less graphic terms:

There was a Mr __ who got all the cases in No 2 to dress, but until then I had not known what a 'cruel dresser' meant as my sufferings only began then. The first dressing I believed he had again drawn my arm out of the cup & reopened all the wounds etc. The two following nights I slept none at all, & this was invariably the case after dressing me while he was on duty. I felt sure I could not progress under his treatment, and consequently would have to stay a long time still in the Infirmary. (S2, 63)

Her leaning over the bed sobbing, and crying out to Miss Logan 'I have got a cruel dresser!' is not mentioned at all, and the description of the blood running down all over the bed such that the linen required to be changed has been omitted.

When Lister returns from London and asks her how she is getting on, she replies, 'Thank you Sir, but ordinary.' When he responds, 'How is that? You ought to be getting on well by this time', she comments,

I did not answer Professor's question, as I did not wish to inform on Mr __ as there were a great amount of events might come out of it. I was not aware of at the time, and evidently it could only add to my suffering instead of abating it. Thus I avoided giving the information for a time hoping Mr H. would improve. (S2, 63)

When the Professor undoes the bandage, however, he immediately asks 'Dr what's been doing here? Who is now the dresser of this case?'. When told that it's 'Mr H. sir', Mathewson comments, in parentheses, that '(Mr H. was present & took a red face.)', adding the following dialogue between Lister, Mr H., and the other medical students and doctors accompanying him on hospital rounds:

'Well, Mr H. you have not failed to move the joint, but this is too much and has reopened what was now set together, and thus retarded the healing process. And then the pain it must have given the patient. Did she ever report you to Dr Roxburgh?' Dr Roxburgh said 'Never to me, Sir.' Prof. then asked me 'Did you always feel pain after the dressing?' 'Yes Sir.' 'And did you always sleep well the following night?' 'No Sir, for the two following nights I seldom slept any.' 'Do you think Mr H. did it intentionally to cause pain?' 'No Sir, I think Mr H. did it chiefly so as to secure good movement of the joint, so as I should not have a stiff joint. Prof. then patted me on the back, and said, 'You are a considerate and patient young woman.' 'Now Mr H. you see she has not said a word against you, therefore you will surely treat her more kindly.' 'Yes, Sir.' 'I had to be cautious how I answered Prof. here again, as I believed a great deal would depend on what I said regarding the dressing, as 'Many a word in anger spoken, finds its passage back again' says the poet. (S2, 63–64)

In this version, Lister's question, 'Do you think Mr H. did it intentionally to cause pain?' clearly states his awareness that the dresser's motives might have been purely sadistic. But Mathewson's somewhat confusing account appears to explain her failure to report his cruelty as the fear that he might simply be even more cruel thereafter. The whole episode in the earlier 'Sketch' in which she confronts the student and threatens him with dismissal is omitted. In this later version, she makes a complaint to the dresser only after Lister has questioned the dressings and rebuked the student, and her complaint is far more circumspect:

Prof. then had to go again to London, and Mr H. dressed me again; but his manner of dressing was the same. I then told him I was determined to tell Dr Roxburgh if he did not treat me more gently in moving it. He was a little better after that. (S2, 64)

Her quotation of a line from a poem commonly included in anthologies of poetry and hymns seems designed to give the whole episode a less shocking, more literary character.30

'And what a successful case it came to be'

After a number of weeks spent in the Convalescent Home in Corstorphine and a few more recuperating at her brother Walter's home in Campbeltown, Mathewson was able to return to her home in Shetland. There, having heard that Cheyne was home on the island of Fetlar for his holiday, she went to see him. It was in her view, I believe, a triumphal visit. In her own words:

In the summer of 78 [...] I went to Fetlar to see [Dr Cheyne] for advice on my arm also to let him see its progress. He probed it to see if it was sound at the bone. I felt it in the shoulder cup, and for some days after it was very sore. He asked if it had ever gathered Yes Sir it gathered three times after I came home.' 'What did you do?' I wrote to Dr Chiene Edinburgh and he sent me a drainage tube.' 'And who put it in?' 'Myself, sir, before a glass.' He was very much amused and surprised at this, then had lots of questions; then said, Well

it is quite sound at the bone and it will doubtless get to be as strong as the other yet, and what a successful case it came to be and I am so glad to see it'. (S2, 92)

Mathewson added, in this later version of her 'Sketch':

It healed quite up in August and since feels much stronger. It was 17 months healing. Now I can do any sort of indoor work, even washing clothes, etc. And looking back through this ordeal of trouble, how I am laid to wonder, and adore God's love,

and she concludes with a quotation from a hymn (S2, 93). Little more than a year later, her father wrote to his remaining children, Joanna, Laurence, and others, 'I write to you at present to let you know that I followed my Dear Margaret your Sister to the Grave in the Asaylum [*sic*] in MidYell on the evening of Saturday the 2nd October'.31 In addition to Margaret, he lost two other children that single year of 1880. Arthur died at age forty-one on 20 February 1880, Walter died at age thirty-eight on 31 October 1880, the two brothers most probably, like Margaret, succumbing to tuberculosis (Goldman, pp. 144–45).

Margaret Mathewson's 'Sketch' was not published, even in excerpt form, for over a hundred years. William Ernest Henley's poems about his hospital experience as a private patient of Lister's, by contrast, were published in the *Cornhill Magazine* in July 1875 under the title: 'Hospital Outlines: Sketches and Portraits'.32 His hagiographic poem on Lister, here titled 'A Surgeon', later titled 'The Chief', has been quoted repeatedly in medical journals and elsewhere.33 One could certainly speculate that, in titling the account of her experiences in the Edinburgh Royal Infirmary a 'Sketch', Mathewson encodes her dreams of becoming not only a nurse — even a nurse-surgeon — but a writer. After all, the most popular writer of her day, Charles Dickens, had begun his career with *Sketches by Boz*, in which is included 'The Hospital Patient'.34 What would it have meant had Mathewson lived long enough to publish her 'Sketch'? How would 'hospital medicine' have been changed if Mathewson's 'Sketch' had in turn spawned a genre of hospital patient narratives, parallel to but contrasting with the 'invalid narratives' produced by more elite Victorian writers?35Mathewson's 'Sketch of Eight Months a Patient in the Royal Infirmary of Edinburgh 1877' marks a vital, and perhaps unique, moment in the history of hospital medicine, documenting treatment in one British hospital as seen 'from below'. But this patient charts her medical history as a rise from one subordinated to medical authority to one who speaks — and acts — on her own behalf. When we read this patient's account *in her own words*, we realize that Foucault, Jewson, and others elaborated their theories in the absence of any autobiographical testimony from Victorian hospital patients themselves. While their theories have served well as foundation and ongoing support for the 'patients' rights' movement that emerged in the late twentieth century, we need to heed Porter's charge

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

that those theories are also continuing to reinforce that old stereotype of the basic invisibility — and inaudibility — of the sick. Margaret Mathewson stuffed the sheet in her mouth so she would not 'shout' with the pain. But in writing her 'Sketch', she reversed her self-silencing, and we can hear that shout if we read what she wrote.

Endnotes

1.I thank the Wellcome Trust for partially funding the research for this article. I also thank the Shetland archival staff, especially Joanne Wishart, Assistant Archivist, and Brian Smith, Archivist, for their expert assistance. Margaret Mathewson, 'Sketch', partial holograph manuscript (first six pages) completed by a friend (Laurence Williamson), held in Shetland Archives, #D.7/77, 44–46. Further references to this manuscript are given in the text as 'S2'.

2. I take the phrase, 'from below', from Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98.

3. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Knowledge*,trans. by A. M. Sheridan Smith (New York: Vintage Books, 1994), p. 59.

4.Nicholas D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870', *Sociology*, 10 (1976), 225–44 (pp. 234–35).

5. David Armstrong, 'The Patient's View', *Social Science of Medicine*, 18 (1984), 737–44 (pp. 739, 742).

6. Mary E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*(Cambridge: Cambridge University Press, 1991), p. 148. Also printed as 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine', in *British Medicine in an Age of Reform*, ed. by Roger French and Andrew Wear (Abingdon: Routledge, 1991), pp. 92–109.

7. 'Introduction', in *Patients and Practitioners*, ed. by Roy Porter (Cambridge: Cambridge University Press, 1985), pp. 1–22 (p. 2).

8. W. B. Howie and S. A. B. Black, 'Hospital Life a Century Ago', *British Medical Journal*, 28 August 1976, pp. 515–17; 'Sidelights on Lister: A Patient's Account of Lister's Care', *Journal of the History of Medicine & Allied Sciences,* 32 (1977), 239–51.

9. Martin Goldman, *Lister Ward* (Bristol: Hilger, 1987), p. ix. A selection of excerpts reprinted from those in this work also appears in *Health, Disease and Society in Europe, 1800–1930: A Source Book*, ed. by Deborah Brunton (Manchester: Open University, 2004), pp. 32–36; and Hilary Marland comments on it in her textbook essay for the course: 'The Changing Role of the Hospital, 1800–1900', in *Medicine Transformed: Health, Disease and Society in Europe 1800–1930*, ed. by Deborah Brunton (Manchester: Open University, 2004), pp. 31–60 (p. 56).

10. Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*(Oxford: Oxford University Press, 1999), pp. 361–87.

11. In addition, Risse seems unaware that the version of the 'Sketch' which he cites — a photocopy of the 'Sketch' then held in the Medical Archive Centre at the Edinburgh University Library — is not the same as the version reprinted in Goldman's *Lister Ward*.

12. Margaret Mathewson, 'Sketch', photocopy held in Shetland Archives, #SA.2/340. Further references to this photocopy are given in the text as 'S1'.

13. The exact dates of her work in Edinburgh and Liverpool have not been determined, but evidence from family letters indicates she may have first developed symptoms of 'chest disease' in 1873, and swelling in her armpit as early as March 1875.

14. *Medical Register*, Royal Infirmary of Edinburgh, 23 February 1877, Lothian Health Services Archives, LHB1/126/40.

15. In the later version of the 'Sketch', Mathewson changes her comment about Cheyne's recognition of her to the more socially sophisticated 'Martha was surprised we knew each other' (S2, 5).

16. Uncatalogued letter, Shetland Archives. This letter is partially quoted in Goldman, p. 20.

17. Michael Warboys proposes that although Lister based his system of wound treatment in the 1870s on Pasteur's theory of 'panspermism', he also continued to believe that much wound inflammation was chemical in origin and caused by dead or decomposing tissue in the body. See *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge: Cambridge University Press, 2000), pp. 77–82.

18. Jonathan Gillis suggests that from 1850 on, the trend in patient history-taking moved towards seeing the patient's history as 'a superficial, chaotic story' as contrasted to the physician's 'deep, "true" history'. Lister's history-taking, as recorded by his patient Mathewson, does not quite fit this model, suggesting instead that Lister regarded the patient's story as true but almost inevitably corroborating the physician's diagnosis. See 'The History of the Patient History since 1850', *Bulletin of the History of Medicine*,80 (2006), 490–512 (p. 494).

19. Although the Royal College of Surgeons of Edinburgh Archives holds two ward case-books from the years 1869 to 1870 and 1871 to 1872 which list Joseph Lister as surgeon, Lister did not make any notes himself in these books. Notes were kept by other surgical staff members. No case-books from 1872 to 1880 are known.

20. She commented in a letter dated 6 March 1877 that 'my arm is issuing just about the same as when home and the Drs say while it keeps open they can't open the other abscess'. Uncatalogued letter, Shetland Archives.

21. Roseleyne Rey notes that S. Weir Mitchell's work indicates that there was 'no reticence at all in using morphine' to treat war wounds in the United States, as it was not until 'after the 1870s that the limitations of opiate remedies began to be questioned by the

medical world which, up until then, was not aware of the problem'. See *The History of Pain*, trans. by Louise Elliott Wallace, J. A. Cadden, and S. W. Cadden (Cambridge, MA: Harvard University Press, 1995), p. 229.

According to William Dale, M. D. Lond., 'opium is our ordinary and universal catholicon during the course and specifically towards the close of the fatal maladies at which we have glanced — as cancer, phthisis, asthma, angina pectoris, etc.' See 'On Pain, and Some of the Remedies for Its Relief', *The Lancet*, 97 (1871), 739–41 (p. 740).

23. Uncatalogued letter, Shetland Archives.

24. Uncatalogued letter, Shetland Archives.

25. S2, 28–29. It is also possible that liquid morphine's bitter taste made it unappealing to postoperative patients, or that other ingredients with which it was mixed did so. But it does seem clear that neither Mathewson nor the other patient were aware that it would relieve their pain. Nor does Mathewson ever mention how effective the drug was, or speak of requesting it, as she does of brandy.

26. In the earlier 'Sketch', Mathewson's description of her pain at this first postoperative dressing is similar though a little less elaborate: 'The pain was undescribable as I had never before felt such pain and I almost fainted from it, & the sweat ran down over me like water, and I felt the arm quite loose from my body, & I felt so weak at the thought of having lost my arm after all!!' (S1, 74).

27.

The dresser was almost certainly a 'Mr Hart' who is included in the photograph of Lister's clerks and dressers in 1875, reproduced in M. Anne Crowther and Marguerite W. Dupree, *Medical Lives in an Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2007), p. 4. His full name was David Berry Hart, and he graduated from medical school in 1877 and went on to become a much respected obstetrician and gynaecologist. He is listed as a Resident at Edinburgh Royal Infirmary from November 1878 through May 1879. I thank Laura Gould at Lothian Health Services Archives and Professors Crowther and Dupree for bringing this information to my attention.

28. Shetland Archives, #D23/151/43/1–45.

29. Sally Wilde points out that 'there is now a very considerable body of work that emphasizes the varied and negotiated nature of nineteenth- and early-twentieth-century clinical relationships and the importance of patients as autonomous actors', but her article deals with private, paying patients who began to enter hospitals voluntarily in the late nineteenth century. Also, although she argues that patients had more authority in terms of giving or not giving consent to surgery, she does not consider whether patients, especially non-paying or charity patients, might have had the authority to report abuse by medical staff and cause their dismissal. See 'Truth, Trust, and Confidence in Surgery, 1890–1910: Patient Autonomy, Communication, and Consent', *Bulletin of the History of Medicine*, 83 (2009), 302–30 (p. 307).

30. The poem as quoted in *Sacred Hymns and Spiritual Songs*, Church of Jesus Christ and Latter-Day Saints, 1869, p. 66, is as follows:

31. Shetland Archives #D1/411/3/6. Letter dated 18 October 1880.

32. *Cornhill Magazine*, July 1875, pp. 120–28.

33. The poem following 'A Surgeon', as printed in the *Cornhill*, and titled 'A Student', presents a distasteful contrast to the former. Beginning, 'A little black man', it goes on to describe this student in grossly racist terms. One wonders if the subject of this poem might have been the student identified by Crowther and Dupree in an 1875 photograph of Lister's senior students as George Rice, an American born in New York State, whose race is not mentioned in any contemporary source but is obvious in the photo (*Medical Lives*, p. 3).

34.Charles Dickens, *Sketches by Boz*, ed. by Dennis Walder (London: Penguin, 1995), pp. 277–82.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Article

The Participation of Azerbaijan in the International organizations UN and OSCE and the regulation of the Nagorno-Karabakh conflict

Sevinj Seyidova

Azerbaijan State Pedagogical University, Department of The Chair of Turkic and Eastern Nations history, Azerbaijan, Baku city

Abstract: The Republic of Azerbaijan declared independence in order to gain international recognition in the international arena and bring the truth about the Azerbaijani-Armenian Nagorno-Karabakh conflict to the world community, it was necessary to join the UN. The Republic of Azerbaijan became a member of the United Nations on March 2, 1992 and first begins the struggle for a just solution of international organizations before the relationship to the conflict. The article examines and assesses the role and role of the UN in the Armenian-Azerbaijani Nagorno-Karabakh conflict. The article also analyzes the role of the OSCE Minsk Group in the settlement of the Nagorno-Karabakh conflict and provides a critical assessment of the activities of this group from the standpoint of international law.

Keywords: Nagorno Karabakh, crisis, territorial integrity, conflict, UN, OSCE Minsk Group, ceasefire, resolutions.

Introduction:

This determines the increased attention to conflict with the international community and, in particular, active involvement in its resolution of international organizations. Moreover, the main role of the international community trust is not the UN and the OSCE. Geo-strategic and economic interests in the increasingly difficult to reach a political settlement of the Nagorno-Karabakh conflict.

Discussion

In modern time international organizations is the basic participant of international attitudes. International organizations form with the definite purpose on the base of the treaty, correspond international low. It is union, which has the constant worked

structure. The formation international organization, which work for peace, security and collaboration, is one of the basic development direction and show mutual connection, mutual dependence between events and process in the system international attitudes.

Now in the world are acting over 4000 international organizations and in the result formed separate international organization system in the international attitudes. The international organizations law regulate the action these organizations. International organizations by means of their function participate in the regulate the law of the international attitudes.

An international organization is the instrument of foreign policy and many-sided diplomacy for the states, which formed them. International organizations give the guarantee the independence to the states, which are members and influences to the formation social opinion. It is necessary to draw conclusions that without international organizations activity of a system of the international attitudes not probably. The collaboration with the international organizations is one of the basic problems the foreign polis and diplomacy, and basic direction of foreign policy of Azerbaijan Republic. Azerbaijan Republic support relation to the international organizations for that:

1. Reach the purpose of foreign policy, especially for defense the independence and the safety and use opportunities international organizations.

2. Participate in the many-sided diplomacy.

3. Participation in the world policy and the international attitudes with help international organizations.

4. International organizations defend the position and the policy of Azerbaijan.

5. Use the opportunities the international organizations for the decision Armenian-Azerbaijan conflict.

6. Promote the international social opinion.

7. Propagandize successes in the process construction of independence state.

Discussion

Azerbaijan supports the relation with the international organizations on different level. Azerbaijan collaborates with universal and regional organizations. Azerbaijan became members of the United Nations (U.N.), the Conference on Security and Co-Operation (CSCE/OSCE) in Europe and other international organizations. The participation of Azerbaijan in the international organizations is important, because since 1986/1987 years Armenia calls for re-attachments of Nagorno-Karabakh to Armenian SSR, since 1988 years Armenia began the war against Azerbaijan in order to capture Karabakh – which is an indivisible part of the Azerbaijan Republic.

Since the beginning of 1992 this conflict has became international problem. In 1992 were massacre in Khojaly, Shusha and Lachin regions of Azerbaijan. In 1993 Kelbajar, Agdam, Fizuli, Jabrayil, Gubadli

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

and Zangelan regions of Azerbaijan became the victims of this aggression. As Armenian side continued it's military attacks against Azerbaijan and Azerbaijan appeal to United Nations Security Council in order stop this aggression, U.N. Security Council adopted the following resolutions: 822-April 30, 1993; 853-July 29, 1993; 874-October 14, 1993; 884-November 11, 1993.

On May 8 of 1992 Armenia after the occupation of Shusha, on May 12th of 1992, the Chairman of the Security Council issued a statement about the deterioration of the situation in Nagorno-Karabakh, which occurs in connection with a violation of the cease-fire agreements casualties, significant property damage, and their expressed his concern about the consequences for the countries of the region [16,121]. The statements of August 26, October 27 of 1992 was similar to [5, 61].

On April 2 of 1993, after Armenian troops occupied Kalbajar region, the President of the Security Council on 6 April of 1993 statement by the local Armenian forces expressed serious concern over the invasion of Kalbajar [16, 121]. Finally, on April 30 Security Council of UN adopted resolution No. 822 [24, UN Security Council resolutions, Resolution No. 822 (30 April, 1993) preamble 7th] (3205th sitting). This resolution also criticized the statement famous views of the local Armenian aggression. Resolution of the inviolability of international borders, confirmed the inadmissibility of the use of force for the acquisition of territory, establishing a durable cease-fire order the immediate cessation of all hostilities and hostile acts, and all occupying forces from other recently occupied areas of Kalbajar district and demanded the immediate withdrawal. But who has not been shown to be aggressive. In order to resolve the conflict peacefully, of the OSCE Minsk Group are advised to resume negotiations within the framework of the OSCE and the Chairman of the OSCE asked Minsk Group's Chairman in consultation for to assess the situation. Thus, the UN Security Council just gives advice and is entirely the responsibility of the OSCE Minsk Group on the CSCE and throwing away the solution of the problem itself as an institution.

On July 23 of 1993, Armenia was occupied by Agdam region. Azerbaijan is strongly demanded to withdraw put an end to military operations from Republic of Armenia from the occupied territories. On July 29th of 1993, the UN Security Council in 3259th sitting was adopted the resolution №853[1]. The UN Security Council resolution to endanger peace and security in the region, the situation would be concerned.

Resolution about of Agdam region and the occupation of the occupied regions, attacks on civilians, may discourage the capture of bombardments of residential areas, and who does not name the other occupied territories of Azerbaijan territory was not down artillery fire and bombs. The immediate cessation of military operations and the occupying forces from all occupied territories of Agdam and other regions of

1 24, UN Security Council resolutions, №853 (July 29, 1993) Resolution, the preamble 8th

the Republic of Azerbaijan, full, immediate, unconditional withdrawal was required. But who completely, immediate, unconditional withdrawal was required. All of these shortcomings, the document is incomplete, in fact, draw down its jurisdiction.

On August 23 of 1993, Fuzuli, Jabrayil, was occupied by the Armenians on August 31 Gubadly regions [19, Armenian aggression against Azerbaijan]. On September 28 of 1993 OSCE's Minsk Group in Paris, at the next meeting during a discussion of the "Urgent updated schedule of events" don't take into account Azerbaijan's proposals and Azerbaijan don't adopt this proposals because did not agree with this schedule.

Nevertheless, on October 14th in resolution № 874 UN Security Council welcomed the schedule [24, UN Security Council resolutions, resolution №874 (October 14, 1993) Resolution, preamble 5th]. The resolution called on the parties to accept it and even, "the withdrawal of forces from recently occupied territories, for communication and transport, including the removal of all obstacles", as stipulated in the OSCE's Minsk Group "Urgent updated schedule of events", "immediate and urgent steps in to implement", was calling. But what kind of resolution was talking about forces? Unfortunately, this is not mentioned in the document.

There are tensions, which would create a threat to peace and security between Armenia and Azerbaijan are being made, Armenia was not termed occupation and simply confirmed the presence of indirect conflict with Armenia. However, the sovereignty and territorial integrity, inviolability of borders and the inadmissibility of the acquisition of territory by force was approved for.

No action was taken against the Republic of Armenia at the level of international organizations, Armenia attacked to the south-west regions of Azerbaijan. First Horadiz, then Zangelan region (October 27, 1993) was occupied by Armenia. At the request of Azerbaijan of the UN Security Council looking at the issue again, this time adopted a new resolution (11 November, 1993, resolution No. 884) [24, UN Security Council resolutions, No. 884 (November 11, 1993) resolution, the preamble 6th]. New, №884 resolution of the conflict over Nagorno-Karabakh and continued worsening of relations between the Republic of Armenia and Azerbaijan, however, are the causes of these tensions, Armenia as an openly aggressive. Excessive use of force in this document, the Horadiz, Zangelan occupation of marks, but this occupation who are committed. On the one hand is the Republic of Azerbaijan's territorial integrity and sovereignty, and Horadiz unilateral withdrawal of occupying forces from Zangelan and generally aggressive forces from all regions of the Republic of Azerbaijan occupied withdrawal recently stakeholders is required, on the other hand, referring to Armenia, Azerbaijan's Nagorno-Karabakh region, has to use its

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

influence. Thus, the UN Security Council created the controversial document.

The resolution was estimated through the Russian Federation, it was not at the problem properly. OSCE Minsk Group's "schedule" is proposed to explore the possibilities of resolving the conflict in accordance with the interests of Azerbaijan has not reflected here was not possible to use the document to. UN Security Council "schedule" was estimated also be interested in resolving the conflict, the question of to what extent it was very difficult to answer. In the resolution from international institutions Azerbaijan's Horadiz, Zangelan region and the also the population in southern border of Azerbaijan, including the provision of urgent humanitarian assistance to the affected population, refugees and internally displaced persons to return to their homes in dignity and in danger of being asked to help, it is generally much less positive aspects of the resolution was one. Thus, the UN Security Council's resolutions and considering the statement, witness the Nagorno-Karabakh conflict between the interests of the great powers. France, Russian Armenian position is no doubt that the negative effect of making responsible decisions. US and the UK is defend the interests of the Azerbaijan. Russia, France, and the US states of the OSCE Minsk Group co-chairs, and there is great interest in Azerbaijan. Each of the three co-chairing countries want to resolve the conflict peacefully, but this request has not been realized yet.

On September 29 of 1994 at the 49th session of the UN General Assembly, the President of the Republic of Azerbaijan Heydar Aliyev made a speech, about the Armenian aggression against Azerbaijan to the whole world [17, "at the 49th session of the UN General Assembly, the President of the Republic of Azerbaijan Heydar speech "(New York, September 29, 1994) historical document. August 2005.15].

On 27 July - 4 August of 1997 the President of the Republic of Azerbaijan Heydar Aliyev's visit to the US and met with UN's Secretary General Kofi Annan in the UN headquarters in New York (July 28). In this meeting was shown Azerbaijan's position which to integration with the international community once again. The President's speech, spoke about the aggression of Armenia, Nagorno-Karabakh conflict settlement was considered important to influences. He was calling The United Nation's Security Council resolutions for the implementation. The President also spoke about the fact that Russia's sold to Armenia $ 1 billion worth of weapons, pay attention to this issue and emphasized the importance of the United Nations and other international organizations. He told to settle Armenia-Azerbaijan, Nagorno-Karabakh conflict's on the basis of Lisbon and he was defender this basis. [17, "The President of Azerbaijan Heydar Aliyev at the meeting with UN Secretary General Kofi Annan" (New York, UN Headquarters, July 28 1997 year) historical reference document. On May 17, 2006].

On 15 December of 1999, the 54th session of the UN General Assembly by a majority vote (of the 188 UN member state), "Cooperation between the United

Nations and the OSCE," the resolution was adopted, the resolution of the Nagorno-Karabakh as part of Azerbaijan shown [23, 54th session of the UN General Assembly. December 1999. 15].

On the initiative of the UN General Assembly agenda 59th session "The situation in the occupied territories," and this item was discussed on the 163-paragraph discussion of the fact-finding mission within the framework of the OSCE Minsk Group from January 30y to February 5th, 2005 to the occupied territories of Azerbaijan [19, Statement of the Ministry of Foreign Affairs on March 22, 2005]. According to the Azerbaijani side, 20-23 thousand people were moved from the regions occupied by Armenia, the Armenian population never living in the Lachin region were transferred to 13 thousand people [19, Statement of the Ministry of Foreign Affairs on March 22, 2005]. However, the report of the fact-finding mission less than the figures shown, in general, deportations, 15-16 thousand people, Lachin region, was transferred to the 8-12 thousand people [15, 223, 242].

As you can see, the mission may have undermined the party's figures, facts in fact approved. The mission of the "occupied territories weren't transferred again", "not to allow changes in the demographic structure of the region," seriously complicates the peace process calls and it was noted [19, Statement of the Ministry of Foreign Affairs, March 22, 2005].

Flagrant violation of the UN Charter, international law should impose sanctions against the Republic of Armenia. Otherwise, the UN Armenian-Azerbaijani, Nagorno-Karabakh conflict can be reduced to the role and attempts to draw. The right of peoples to self-determination, no right to occupy the territory of another state by state of war, and not authorized. This is the core of international law - which prohibits the use of force and the seizure of land is a violation of the rules. The efforts to achieve a peaceful and constructive resolution of the Nagorno-Karabakh within Azerbaijan is ready to grant the highest autonomy status. In the Nagorno-Karabakh of Azerbaijani and Armenian community of peaceful coexistence, cooperation enables the formation of legitimate regional authorities could create conditions to perform. This is exactly what has the right to self-determination.

On 14 March of 2008 - in The UN General Assembly 62 session have been adopted in the A/RES/62/244 Resolution sovereignty of the Republic of Azerbaijan, was reaffirmed the inviolability of internationally recognized borders [15, 403-404]. Of all Armenian forces from all occupied territories of Azerbaijan immediate, complete and unconditional withdrawal was requested. Thus, the conflict to respect the territorial integrity and internationally recognized borders, as well as Azerbaijani and Armenian communities of Nagorno-Karabakh, and there can be adjusted on the basis of peaceful coexistence. These resolutions corroborated the territorial integrity

of Azerbaijan Republic. However, Armenia ignored these resolutions.

After membership Azerbaijan Republic in the conference on Security and Co-Operation in Europe, in March 24 1992, the CSCE Ministerial Council of Senior Official adopted the decision, which emphasized necessity to hold CSCE Minsk Conference in order to settle this conflict. USA, Russian, Turkey, Italy, Germany, France, Sweden, the Czech and Slovak Federal Republic, Belarus, Azerbaijan and Armenia participated in this conference in Minsk and formed Minsk Group for solution Armenia-Azerbaijan conflict. In May 1994 ceasefire confirmed through OSCE med ration, but it didn't solve this problem. From 1992 to nowadays Armenia-Azerbaijan conflict of OSCE is one of the most controversial issues. In 1997-1998 OSCE offered "new proposals" for solution this conflict. The new proposals contain the formation of a confederative state including Azerbaijan and Karabakh. These proposals were accepted by Azerbaijan and by Armenia. The USA takes the initiative of Karabakh peace process and pressurizes Baku and Yerevan. The presidents of Azerbaijan and Armenia met several times face to face under American sponsorship. Unfortunately those discussions ended with out any result. Undoubtedly, in all these cases only the Armenia Government and the armenias living in Nagorno-Karabakh are to be blamed. And there is only one answer to this question .Armenian always tries to prove that this conflict is only between azerbaijanias and armenias living in Nagorno-Karabakh.

In modern times, a number of global problems, conflict resolution interstate Security and Cooperation in Europe, the OSCE plays an important role. The OSCE is trying to solve one of the problems of the Armenian – Azerbaijani, Nagorno-Karabakh conflict. In March 1992, the OSCE Minsk Group, Armenia-Azerbaijan's Nagorno-Karabakh conflict can not be considered satisfactory so far, because of the frozen conflict. First of all, who conflict contradictions remain between the parties as well as the Minsk Group member states, and there is no consensus in the positions about the conflict available in the controversy.

On April 11-15 of 1994 in Prague, the next meeting of the OSCE Minsk group passing measures to strengthen confidence in the plan. Nine countries by Minsk Group adopting a new statement expressed concern over the escalation of hostilities in Nagorno-Karabakh. The plan is similar to the agreement prepared by Russia. In turn, Azerbaijan side notified that, Armenia to withdraw its troops from the occupied territories of Azerbaijan, including Shusha and Lachin, if you can begin negotiations on the status of Nagorno-Karabakh in Azerbaijan, as well as the mediation of Russia as well give up. However, it should be carried out under the mediation of OSCE Minsk Group. In turn, the CSCE Minsk Group on Nagorno-Karabakh under international control of the weapon should be given by any country [11, May 6, 1994 - №6].

The members CSCE Minsk Group to consider the proposals give a word of it,

had been placed under international control arms sales to Nagorno-Karabakh.

On May 4-5 of 1994 in Bishkek, the capital of Kyrgyzstan was held at the initiative of the CIS Inter Parliamentary Assembly. Bishkek meeting passed under the auspices of the Russian Federation Council of Russia V.Sumeyko, was part of the Russian president's special envoy V.Kazimirov. He is one of the main participants in the preparation of Bishkek protocol. At the meeting Azerbaijan side is represented deputy chairman of the National Assembly of Azerbaijan A.Jalilov, Armenia side represented Armenia's Parliament Speaker B.Ararktsyan and at the meeting as well as representatives of the Armenian community of Nagorno-Karabakh K.Baburyan and Azerbaijani community of Nagorno-Karabakh N.Bəhməmov participated in. The main purpose of the meeting was to sign a ceasefire between the conflicting parties.

Some provisions of the protocol did not satisfy the Azerbaijani side. Therefore, the provisions changed "seized territories", "occupied territories" was replaced with the term. Also, "observers" term "international observers" were replaced with. This in turn has given the international nature of the conflict. As well as the conflict must be resolved within the framework of the OSCE Minsk Group was ranked as. It continued to pressure from Russia [2, International Relations Department, the Governor's meetings, January 8 - March 12, 1997, pp. 90-91].

President Heydar Aliyev during their meeting in Bishkek in Brussels. Because He wasn't signed final protocol in Bishkek. On 8th May, after returning to Baku, President of Azerbaijan Heydar Aliyev meeting and V.Kazimirov other officials. Finally, on May 12, 1994, and Azerbaijan and Armenia and Nagorno-Karabakh signed a ceasefire was declared and the Protocol entered into force [2, International Relations Department, the Governor's meetings, January 8 - March 12, 1997, pp. 90-91]. 1994 - July 18 - The Russian Foreign Ministry issued a statement on the achievement of a cease-fire brokered by Russia [14, 34].

Budapest Summit (5-6 December 1994), the OSCE Minsk Group rivaling Russia and had an important role in resolving the conflict. After the Budapest summit of the OSCE activity, improved, expanded and upgraded. Held on December 2-3, 1996, at the Lisbon summit, the new co-chairs of the OSCE Minsk Group was appointed, it was France, and the United States. The Armenian - Azerbaijani talks to some extent affected. Minsk Group co-chairs of the Lisbon summit, which forms part of the settlement of the Nagorno-Karabakh's conflict 3 principles were recommended, which was supported by all Member States of the OSCE Minsk Group. These principles are:

- Territorial integrity of the Republic of Armenia and Azerbaijan;

- Based on self-determination of Nagorno-Karabakh within Azerbaijan, Nagorno-Karabakh defined in an agree-

ment to grant legal status to the highest degree of self-government;

- To ensure compliance with the provisions of the settlement, including the mutual obligations of all parties to ensure the security of Nagorno-Karabakh and its whole population [4, OSCE - Summit in Lisbon on December 3, 1996 - added 1; OSCE - Statement by the Chairman; added 2].

Minsk Group co-chair of the Lisbon summit was also determined. It was the French government representative Jacques Blo [19, The Ministry of Foreign Affairs of the Republic of Azerbaijan and OSCE]. France is one of the co-chairs as well as it was in the interests of Armenia and Russia. Just seeing a change in the situation of this kind of third-nominated co-chair, and it was the United States. Take into account the interests of the French-Armenian resolution of conflict caused doubts arising out of the side of the reality of this step was necessary.

On February 14, 1997, the OSCE Minsk Group were founded 3 side co-chairmanship (Russia, USA and France) [19, The Ministry of Foreign Affairs of the Republic of Azerbaijan and OSCE]. OSCE Chairman Nils Peters (Denmark), US Deputy Secretary of State Strobe Talbot was appointed co-chair of the OSCE Minsk Group and the negotiations were a novelty.

In 1997, in consultation with the parties to the conflict in Minsk Group co-chairs made a few suggestions. On June 1, 1997 plan drawn up "package settlement plan" proposed by the Minsk Group's important, though, after some adjustments, from side was accepted. According to this plan, the status of Nagorno-Karabakh, the liberation of the occupied Azerbaijani territories by Armenia and other issues had to be resolved at the same time. Armenia did not accept this option. On July 18, the "solution-phase 'version of the OSCE Minsk Group was created and during his visit to the region on 23-24 September sides of the conflict" solution-phase ", the plan was offered. According to the gradual resolution of the conflict in the first stage of this plan, which is adjacent to Nagorno-Karabakh, Armenia occupied Azerbaijani lands to be released, was released in the second stage of Shusha and Lachin, it was determined the status of Nagorno-Karabakh. The Azerbaijani side agreed with this proposal. However, Armenia adopted the first option, but then did not accept the offer by the political games and corruption. Finally, on November 8-10, 1998, the OSCE Minsk Group co-chairs of the "common state" of the world that have not been applied in practice, international law, and also put forward a plan which is contrary to the laws of the state [2, f. №2941 list of stock №, folder №899, February 16-24, 2001, №1-II QR., №1 QR-II. 24 February 2001, №1-II QR].

November 18-19, 1999, OSCE summit was held in Istanbul. The President of Azerbaijan H.Aliyev once again demand the release of the occupied territories and called for the resumption of negotiations within the Minsk Group. He particularly emphasized the double standards of the conflict broke out against it[19, The Ministry of

Foreign Affairs of the Republic of Azerbaijan and OSCE]. In general, the OSCE Minsk Group during the years of 1992-1999, Armenia - Azerbaijan, Nagorno-Karabakh conflict settlement activity in the direction of the price if we did not regret it, we can see no results.

Despite all these attempts, the OSCE continued to work on the settlement of the conflict. In May 2000, the OSCE Minsk Group Co-Chair Kerry Cavanaugh visited the region met with the presidents of Armenia and Azerbaijan, Nagorno-Karabakh was gone as well. On May 9th Kerry Cavanaugh meeting The President of Azerbaijan Heydar Aliyevand discussed the current situation in Nagorno-Karabakh, as well as in the restoration of the occupied territories had a conversation (11, may 11, 2000 №87). The main reason for this meeting, the peace process did not result in the Armenian Parliament in October 1999 as shown in the murder. However, On December 11 of 2000 the during a meeting at the presidential palace Minsk Group to expand its operations advice, the co-chairs Carey Cavanaugh (USA), Jean-Jacques Gaillard (France), Nikolay Gribkov (Russia), referring to the position of their states, the conflict expressed their interest in bringing them (11, on may 11, 2000, №87) in practice, all of which are reflected not only in the documents, were ineffective in the particular case. The position of the OSCE double standards in dealing with conflict, the lack of a mechanism to adjust the conflict, which has a real effect is damaging the reputation of the OSCE Minsk Group, reduced expectations. The position of the OSCE double standards in dealing with conflict, the lack of a mechanism to adjust the conflict, which has a real effect is damaging the reputation of the OSCE Minsk Group, reduced expectations.

Overall, in 2000-2001 Minsk Group's co chairs 3 times to visit the area, visiting the occupied territories, were familiar with the situation. Increased hope that the conflict will be resolved in 2000-2001, the change of power in Russia, because Russia's position influenced on Nagorno-Karabakh conflict. In 2001 affect all three co-chairs were very successful and busy activity. On January 26 at the initiative of the French president Jacques Chirac in Paris, talks took place between the presidents of Azerbaijan and Armenia. The second meeting was held in Paris on March 4-5 and continued negotiations [13, 205]. At the end, On April 3-7, the US state of Florida began the discussions in Key West (11, April 5, 2001, №83). It looked forward to the debate.

Kerry Cavanaugh, one of the co-chairs of the United States, said in an interview with Trend that the positive agreements may be done by the end of the meeting. He is both the president to end the conflict peacefully demonstrating viability was noted (11, April 5, 2001, №83). However, the Key West talks with not positive results caused by the fact that the case is too big pretension of Armenia. At the meeting Azerbaijan President's Heydar Aliyev clear-

ly and sharply condemned the Armenian position. Excessive concessions to the Key West talks requirement for submission of Armenia, Armenia-occupied territories in return for the release of the fact that the UN Security Council to impose certain conditions, as well as the execution of decisions and resolutions were adopted by the OSCE. This requires the implementation of resolutions and decisions, rather than thinking of new variants of the OSCE, made plans.

At the end of 2001 changed the OSCE Minsk Group co-chairs. These were Rudolf Perina (USA), Philippe de Surmen (France), Nikolay Gribkov (Russia). Rudolf Perina, who visited the area in October 2001, with the invention of Azerbaijani President Heydar Aliyev [17, "The meeting Azerbaijani President Heydar Aliyev, with the OSCE Minsk Group co-chair of the United States, Rudolf Perina" (Presidential Palace, October 25, 2001) Historical document. 2006, March 28]. As long as the co-chair of a number of controversial statements R.Perina was created. In the meeting R.Perina spoke about Article 907, and there was the possibility to stop him.

At the end of 2001 (December 4) in Bucharest meeting of the OSCE Ministerial Council of the court's decision on the peaceful settlement of the conflict the importance of continuing the dialogue was recorded. Parties to the conflict to be resolved as soon as possible on the basis of norms and principles of international law, efforts were advised to continue2.

Although there is no result of these challenges, the Nagorno-Karabakh conflict settlement within the framework of the OSCE Minsk Group to conduct intended to continue in the following years.

On January 25, 2002, which prohibits US government assistance to the state of the application of Article 907 has tentatively decided to keep. Very little of it would have been viewed as a victory, but the temporary suspension of this article can not be called satisfactory. March 8-9, 2002 at the Minsk Group came to the region and made a new proposal. The co-presidents of the negotiation process to resolve the conflict was offered the appointment.

The France co-chair Philippe de Surmen new proposals also stresses that, in fact, a revised version of the plan was the old solution (On march 6,7,2002).Special representatives for negotiations to resolve the conflict presidents met in Prague on May 13-15. Even if you have a difference of opinion between the parties, it was regarded as a positive development in the international community meetings [25, Nagorno-Karabakh: Risking War. Report of the European N.187 – November 14, 2007, International Crisis Group]. Special Representatives met On July 2002, in Prague, On November in Vienna. On 14 August 2002, the Azerbaijani sector of the border between Armenia and Azerbaijan's

[2] 21, 9th meeting of the OSCE Ministerial Council, Bucharest, December 4, 2001, the third statements of the Council of Ministers. Decision № (5)

Nakhchivan Autonomous Republic Sederek the two countries was held in Heydar Aliyev and Robert Kocharian. December 11, 2002, "Echo of Moscow" radio station in an interview with the chairman of the OSCE Minsk Group Rudolf Perina, with access to the contrasting expectations of the issue can be solved fairly reduced [28, the interview of Rudolf Perinanın "Echo of Moscow», December 2002.11, clock 15:35]. He is said Nagorno-Karabakh conflicts differ from former Soviet region of (Abkhazia and South Ossetia, Transnistria). R.Perina the above-mentioned states recognized by the international community, the Nagorno-Karabakh conflict will be resolved through negotiations, the parties said they would help you to make a decision. At the end of 2002 (December 7) in the statement of the OSCE Ministerial Council meeting in Porto expressed regret unsettledness of conflict and conflict resolution only for the continuation of meetings ovation.

In 2003, it was in this spirit of all meetings and negotiations. 2003 was a year of hard trials. At the beginning of the year ethnic conflict between Armenians and Azerbaijanis reported that the President of Armenia. The Secretary General of the Council of Europe on January 30 U.Svimmer regret the statement said. In particular, given the statement on the eve of presidential elections in Armenia was regarded as a bad strategy [19, Armenian agression against Azerbaijan. Conflict between Armenia and Azerbaijan. Facts and developments]. On June 19, the Armenian government introduced a 4-year action plan to parliament. The program "defense and security", which stated in part that the government sees the Nagorno-Karabakh problem in the framework of the peace process and the "Nagorno-Karabakh," the people's right to self-determination and the international recognition of Nagorno-Karabakh, in particular highlights of security guarantees its population. "Nagorno-Karabakh Republic" is not likely to be the subject of [19, Armenian aggression against Azerbaijan. Conflict between Armenia and Azerbaijan. Facts and developments].This program is very clear its position in Armenia.

The next presidential elections in Azerbaijan was held on October 15 and was elected President of Azerbaijan Ilham Aliyev. After that talks between the two leaders was restored. On December 11, 2003 in Geneva, Armenian President Robert Kocharian met with President of Azerbaijan Ilham Aliyev [11, December 23, 2003].

The OSCE Minsk Group co-chairs of the so-called "new" proposals put forward. They had previously put forward to resolve the conflict "package solution", with the option to "step solution» variants were synthesized [11, December 23, 2003].This meant to synthesize what? First of all Armenian forces occupied the southern direction, 3, or 4 to get out of town, roads, communication lines open, the economic relations between Azerbaijan and Armenia should be restored and peacekeeping troops

were in the conflict zone. It was then determined the status of Nagorno-Karabakh. Shusha and other occupied territories agreed upon between the parties to the status of Nagorno-Karabakh could be released. As you can see, it was the worst of the plans offered this option has been synthesized.

As for the status of Nagorno-Karabakh, they have two options:

1) is contrary to the interests of Azerbaijan, Nagorno-Karabakh Republic is Nakhchivan Autonomous Republic - is the status of the state and is part of the Republic of Azerbaijan. "State" means giving greater powers to Armenia and Nagorno-Karabakh to Armenia in the future could require more rights.

2) Co-Chairs 'national' proposed to establish that the information given above. This proposal does not reflect the interests of the interests of the co-chair countries. In particular, the realization of this plan coincided with the interests of Russia in active negotiations. In particular, the realization of this plan coincided with the interests of Russia in active negotiations. Communication lines, in particular, as a result of the launch of the railway in Russia, first of all, could create closer economic ties with Armenia. Russia took the opportunity to expand cooperation with Iran.

In 2004, the settlement of the Nagorno-Karabakh conflict within the framework of the OSCE Minsk Group talks intensified further. March 15-16, 2004, the OSCE Chairman-in (Bulgarian Foreign Minister) Solomon Passy arrived in Baku during the visit of the South Caucasus region [6, March 2004, №1]. The visit was to get acquainted with the problem of Nagorno-Karabakh. In such a situation, "Is there a need for the OSCE Minsk Group ineffective?" The question sounded more frequently in the community. Minsk Group were of the next "constructive talks". "Prague" in the name of the meetings was held on April 16, 2004, on June 21, and August 30 [25, Nagorno-Karabakh: Risking War. Report of the European №87, November 14, 2007, International Crisis]. These meetings were not getting positive results were considered positive. Since April of 2004, one of the co-chairs of the OSCE Minsk Group, a representative of the United States was replaced by R.Perina Steven Man. On April 28-30, 2004, Warsaw, had a meeting of the Presidents of Armenia and Azerbaijan. Overall, in 2004, the conflict has intensified negotiations within the framework of the OSCE Minsk Group was still frozen.

Emerged again from the beginning of 2005, the negotiation process. On 11 January 2005, the Ministers of Foreign Affairs of the Republic of Azerbaijan and Armenia with the participation of the OSCE Minsk Group co-chairs meeting in Prague passed. The "Prague process", meant to last. The end of January, beginning of February, including the OSCE Minsk Group co-chairs of the OSCE mission visited the conflict region. Azerbaijani President Ilham Aliyev during the visit of the OSCE Minsk Group co-chair Bernard Fassier, the French agreed [9, Nash vek" newspaper, January 28 - February 3, 2005].

This meeting will be based on the principles and norms of international Azerbaijani President Ilham Aliyev and the Armenian-Azerbaijani Nagorno-Karabakh conflict, stressing that the only way to resolve. Among these norms and principles of territorial integrity and inviolability of borders is particularly important.

OSCE Minsk Group co-chair Bernard Fassier as a whole in 2005, according to the co-chairs of the Foreign Ministers of both countries met 12 times, 3 times visited the conflict zone [18, April 11, 2006)]. In 2005 In Prague (January), Warsaw (May), London (April), Paris (June) caused controversy after meeting certain principles being discussed.

Azerbaijan's Minister of Foreign Affairs Elmar Mammadyarov said the information given by the agency in the early stages of negotiations occupied by Armenia, Nagorno-Karabakh region and 7 surrounding the return of the refugees to return to their land and gave information about the deployment of peacekeeping troops in the area (16 July 2005)[20, Karabakh talks activated, June 2, 2005]. In turn Armenia's Minister of Foreign Affairs V.Oskanyan at the press conference negotiations four under way to resolve the question of the status of Nagorno-Karabakh, if noted, voiced their opinions about the possibility return some regions (30 May 2005) [20, Karabakh talks activated, June 2, 2005].

Azerbaijan's President Ilham Aliyev stated the official position of Azerbaijan at the session National Assembly of Azerbaijan (December 2005). He is said the Nagorno-Karabakh conflict "phased plan" to be resolved on the basis [11, December 30, 2005].Evaluating the work of the Head of the OSCE Minsk Group ATƏT this structure is interested in solving the problem, he said, and the Armenian-Azerbaijani Nagorno-Karabakh conflict will be resolved on the basis of the principle of territorial integrity of Azerbaijan stressed. he has over said 10 years of talking about mutual concessions from Azerbaijan made by the grace of Armenia that the negotiations. Armenian President Robert Kocharian the Minsk Group of the independent Nagorno-Karabakh would be if he did not resolve the issue or would be included in Armenia, in fact, preferred to engage in political blackmail. Armenia and the Armenian population of the occupied territory place, historical monuments of their own is the best case, worst case is completely destroyed. The Armenian side is pretty good position to benefit from the OSCE Minsk Group indecisive.

Above, we discussed the various provinces in order to resolve the conflict talked about the principles. On June 22, 2006, the OSCE Permanent Council in Vienna at the next meeting of the OSCE Minsk Group over the next declaration Elaborating on these principles has officially on the agenda. 1) gradual withdrawal of Armenian troops from the occupied areas of Azerbaijan (Nagorno-Karabakh and the surrounding regions are considered) comment on specific regions of Lachin and Kelbajar. (Not

intended to be a bit late in the demilitarized). 2) The regional disarmament. 3) to determine the legal status of Nagorno-Karabakh, a referendum. The parties agree on the referendum process and the format of the negotiations. 4) the temporary status of Nagorno-Karabakh. 5) Position the international peacekeeping forces in the region. 6) established a joint commission to carry out the contract. 7) International financial assistance from the occupied territories cleared of mines, restoration work should be carried out. 8) The parties must give up the demonstration of the power of the threat and must ensure security and international[18, OSCE Minsk Group co-chairs of the negotiation process on the settlement of Nagorno-Karabakh conflict has issued a statement regarding the situation. July 3, 2006].

In our opinion, the beginning of the Armenian-Azerbaijani conflict, the UN and the OSCE Chairman-in-time, just follow the resolutions and decisions were made, that is, they did not remain on paper only, the conflict would become frozen today. In Madrid, the capital of Spain on November 29, 2007 OSCE the member states of the Council of Foreign Ministers meeting of the Ministers of Foreign Affairs of Azerbaijan and Armenia "Minsk Group" by the co-chairs of the "Madrid principles" of the Karabakh talks since the project was presented and carried around these principles.

Moscow Declaration (November 2, 2008), which is reflected in the Madrid principles was unacceptable to some of the issues. In general, the principle of mutual concession preferences of the Minsk Group, the position of double standards, as well as the OSCE's inability to impose sanctions on those who violate international law in the process of settlement of the conflict is one of the major defects. OSCE official recognition, but the fact of occupation of Azerbaijani territories, if serious action against it, of course, to resolve the conflict is real and it is possible to achieve a positive result. Failure of the OSCE Minsk Group in the resolution of this problem is the fact that the main reason mentioned above. On December 1, 2009 in Athens as part of the 17th meeting of the OSCE Ministerial Council of the 3 + 2 format on the settlement of Nagorno-Karabakh conflict was held. Co-Ministers of the settlement of the conflict in my mind the need for the introduction of a single principle, agreed to come and talk about it, reflecting on the paper when the conflict will be resolved, but they could not say no opinion. French Foreign Minister Bernard Kouchner said on the first day of the meeting: "It is not possible to force the parties to the peace process. The parties do not go over the top, because it is a very sensitive issue. As to the issue of Nagorno-Karabakh, a very complicated geopolitical situation in the region. Geopolitics - this is a complex issue and geopolitics. Therefore, we can not solve the conflict "[26, Az/News/Politics. 2009, 29 dekabr].

Minister emphasized geopolitics is undoubtedly a complex issue, the that the key figures of geopolitics Russia, the US and the European Union is aware of the complicated game. Each of the three geopolitical figure does not want the resumption

of hostilities between Azerbaijan and Armenia. US and Western powers to resolve the conflict (by all means, including demand concessions from Azerbaijan), Armenia and the whole South Caucasus region of the Russian free from the influence of NATO and the European Union's sphere of influence by reducing the desire to participate in various projects in the region. Russia is in favor of freezing the conflict. Because of the conflict in the South Caucasus, remains to be frozen, allow to strengthen the position.

Conclusion

However, in the South Caucasus, Russia is in control. The position of the first day of the conflict facing the above-mentioned parties. It slows down the work of the OSCE Minsk Group, led by powerful states in the world, it is the victim of geopolitics. However, their approach to the double standards of the world's strongest powers in the conflict and the position of the defense of fair and if they are able to bring the timing of the resolution of the conflict.

But in reality Armenian Government has always played a leading role in this aggression. Armenian side doesn't want to make any step in order to solve this conflict peacefully. In order to stop the aggression the international community should respond appropriately in accordance with international legal norms and principles of the United Nations Charter.

President of Azerbaijan Ilham Aliyev of Azerbaijan's position on the conflict, he said firmly: "Azerbaijan's territorial integrity is not a subject of negotiations, has not been and will never be. Nagorno-Karabakh will never be independent, it is not possible without the consent of Azerbaijan. Azerbaijan cannot agree to it ever. The status of Nagorno-Karabakh Armenians and Azerbaijanis who will live within the autonomy of the world's most advanced experience in this field should be applied. This is our principal position, and we will not back down from this position. We will try all the possibilities - political, economic, diplomatic, and other capabilities - switch, this issue soon, with justice, that in accordance with international law, citizens can return to their homeland as soon as possible" [1, 38 - 41].

Reference

1. Azerbaijan President Ilham Aliyev on the occasion of the World Azerbaijanis Solidarity Day and New Year's greetings to the Azerbaijan people. December 31, 2009, S.38-41 President Ilham Aliyev and Culture (2008-2013). Vol. 2. Volume II. Baku, "East-West" Publishing House, 2013, 624 p.
2. Archives of the National Assembly of the Republic of Azerbaijan, International Relations Department

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

3. Archives of the National Assembly of the Republic of Azerbaijan f. 2941
4. OSCE. Summit. Lissabon. December 3, 1996. Appendix 1. Statement of the OSCE Chairman-in-Office Activity-acting; Appendix 2. Statement of the Armenian delegation, http://www.osce.org/documents/1990-1999/sammits/.
5. AKHMEDOV E. Armenian aggression against Azerbaijan and international organizations. Baku: Tuna, 1998, 137 p.
6. "Bizim esr" newspaper (references are given in the text) (Our Age) March 2004, №11 (988).
7. "Respublika" newspaper yanvar 2010 001
8. "Turan news agency" reports, June 19, 2001.
9. "Nash vek" newspaper 28 января-3 февраля 2005 года.
10. "Nezavisimaya gazeta" newspaper 7 марта 2002 года.
11. "Zerkalo" newspaper за 2001-2005-е годы.
12. "Ekho" newspaper 11 апреля 2006 года.
13. VAAL T. Black Garden. Between peace and war. II.bbc.Russian.com. - http://www.News.,bbc.co.uk./Russian-4685000/4685287.stm-2005.r.; http://raufray.files.wordpress.com/2010/11/0814719449.pdf
14. SAFAROV P.S. The international situation and foreign policy of Azerbaijan in 90 years. Methodical instructions. Baku: Azerbaijan State Pedagogical University named after N.Tusi University Publishing House, 1999, 117 p.
15. From Meiendorf to Astana: fundamental aspects of Armenian-Azerbaijan Nagorno-Karabakh conflict / Edited G.M.Alekseeva (doctor of historical sciences, professor of Moscow State University mi. M.V.Lomonosova). MM: 2010, 552 p.
16. Contested borders in the Caucasus / edit. Bruno Coppieters. M.: "All The World", 1996, 226 p.
17. http://www.aliyevheritage.org
18. http://www.apa.az
19. http://www.mfa.gov.az
20. http://www.news.bbc.co
21. http://www.OSCE.Org./docs/1990-1999/ 9th meeting of the OSCE Ministerial Council, Bucharest, December 4, 2001, the third statements of the Council of Ministers. Decision N.2 (5).
22. http://www.azeri.ws
23. http://www.un.org/russian/documen/convents/politpact.pdf
24. http://www.un.org/Doc/scres1993/scres93.htm qə tnamə lə r
25. http://www.az.trend.az
26. http://www.mns.qov.az
27. http://www.echo.msk.ru program s/beseda205961

Article

Allegorical image of time in the European tradition of painting

By: Elkins Carolyn

UK. London Univ., Department of Untold Story of Britain

Abstract

In the late afternoon on my last day in Broome I travelled by mini-bus with several other out-of-towners from the seminar to Gantheaume Point. This is a place where tourists flock to see world-famous one-hundred-and-thirty-thousand-million-year-old fossils of dinosaur footprints. Broome's Tourist Information Centre warns that searching for traces from the past can be dangerous business: Be warned that the terrain becomes rough, steep, unstable and slippery. You should only attempt to climb down to the intertidal area if you are fit and healthy and wearing sturdy, non-slip footwear. It is not recommended to search for the footprints after dark and take note of all warning signs. But our group had not come to see the fossils. Instead we clambered over the sharp edges of the point's red ochre-coloured rock faces to find a perch where we could watch the setting sun. As with most days in Broome, or so I'm told, the sun's blazing red orb sank spectacularly into the distant horizon of the Indian ocean, lighting up the sky in a kaleidoscope of colour: red, yellow, orange and violet blue. The disappearing light soon cast a melancholic mood, reminding me of Michael Taussig's idea that 'in a beautiful sunset we see deepening shadows of despair, and maybe this is why they are beautiful. This is the beginning of twilight, the witching hour when light transforms itself and makes other worlds possible' ('When the Sun Goes Down' n.p.). Taussig's interest in the role of the sun in our cultural imaginations leads him to ponder ways of being in the world that allow for wonder, confusion, intuition and daydreaming. In other words, ways of re-enchanting the world, which he argues is both much-needed now and inspired by the truly unthinkable possibilities of climate change. As

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

with Pigram's allegorical performance of the turning tide in the scene from Gudirr, Gudirr the previous day, Taussig urges us to see that the germ of hope in a beautiful sunset's display of disappearance lies not in the dream of the eternal return of sameness but in the transformative power of difference opened up in the space of the setting sun's enfolding darkness. Despair can give rise to tragedy. But as a rupture to everyday rhythms it can also (re)connect us to the rich life of subterranean worlds of spirits of the dead that lie in wait for us beyond the glaring brightness of enlightenment and progress.

Keywords: allegory, image, self-mutilation, sensibility

Introduction

In Broome, Swain and Pigram are not alone in the cultural work of 'memory of tradition' of Australia's other cultural histories and alternative ways of being in the world. Indigenous cultural production as the continuation of Indigenous culture and as a living and continuously adapting culture is flourishing, from Wawili Pitjas' Jandamara (with ABC TV) and the popular culturally-based TV cooking show Kriol Kitchen to the beautiful songline animation Lurujarri Dreaming (Bernadette Trench-Thiedeman with Goolarabooloo community 2012), Goolarri Media's video-training workshops, Magabala Books' publication of works by more than 100 authors, the unique kriol sounds of the Pigram Brothers musical performance, and so on. In the western world the arts are often regarded as different to and separate from the world of politics. In Broome I was reminded that in Indigenous communities, cultural production is considered heavy-lifting and the means of ensuring trans-generational transfer of an Indigenous worldview, which, if we took the time to listen, is precisely what all the reports into Indigenous suicide prevention in Australia say must occur if we are committed to stopping this social emergency (Georgatos). As Marrugeku suggest through their work, such knowledge is crucial to an Indigenous understanding of culture and tradition. In this essay, I have tried to suggest that it is also a powerful critique of the discourse of progress and something we all need to learn if we hope to continue to live in this country, indeed if our fragile planet is to continue to sustain life and the different worlds we make for ourselves and our children.

In Pigram's words of warning. We need to be celebrating these [old] people and their knowledge, and learn from it … If we don't look to our first peoples and their understanding of tree, of land, of natural systems and the way things work, it's all going to disappear very quickly. And I have a feeling we're going to really need that knowledge soon. (cited in Brunes). In her influential text, *The Body in Pain*, Elaine Scarry made a stark division between physical and psychological pain, suggesting that while the latter has permeated almost every form of literature, the former receives little attention.I Yet, as this essay will argue, such a clear distinction between bodily and mental suffering cannot be made for all historical periods. The study of self-

mutilation in later nineteenth-century psychiatry provides a fitting focus for examining the complexity of notions of body and mind in relation to ideas of pain. Today, it is widely accepted that self-inflicted injuries hold psychological or emotional meaning, attached to the pain or ritual of inflicting a wound and the physical injury itself.2 Such has not always been the case. Indeed, for much of the nineteenth century discussion of self-mutilation tended to focus on the physical nature of wounds, rather than on the process of inflicting them, which, it was at first assumed, occurred simply from the inability of the individual to feel physical pain. In the later nineteenth century, however, some alienists (asylum psychiatrists) began to show an interest in examining the 'motives' behind self-inflicted injury and published increasingly on the topic. The reasons recorded certainly included the idea that self-mutilation might *relieve* rather than inflict pain, as Scarry suggests; nonetheless, the somatic language often employed in nineteenth-century descriptions of mental illness tended to mean this relief was expressed in physical rather than psychological terms.3

This essay provides an analysis of the overlapping ways in which self-inflicted injury was understood in relation to pain (or, more often, its absence) during the second half of the nineteenth century. Today, it is often assumed that self-mutilation in past centuries was closely associated with suicide: thus, I begin by exploring the complex way in which the topic of self-mutilation was associated with — and, more importantly, differentiated from — medical, legal, and cultural understandings of suicide. However, I will argue that it is a mistake to read late nineteenth-century British texts solely from this preserve. Physiological and psychological meaning is often hard to untangle in the published texts of asylum psychiatrists, and still more so in asylum records. Their interest in motive cannot thus be regarded as either a simple forerunner of psychological approaches to mind *or* a purely somatic understanding of brain mechanism. Rather, as I show in a comparison of British psychiatric approaches, asylum physicians preferred a socio-environmental approach to the symptoms of mental illness. Finally, I look at two seemingly psychological approaches to self-mutilation — those of Richard von Krafft-Ebing and William James — both referenced by British physicians writing on the topic. Despite the alleged psychological context, ideas of sensation continued to permeate such research at the turn of the twentieth century. I conclude that a study of self-mutilation — a topic associated in various ways with pain and suffering — indicates that we cannot view later nineteenth-century psychiatric ideas in terms of the modern separation between physical and psychological pain.

My research focuses on the published texts of British alienists (and European and American texts cited by them), within the period 1860 to 1900, when the bulk of writing on self-mutilation outside a military context appeared. In addition, I explore the asylum practices of those writing on the topic, including George Savage, Theo Hyslop, and Daniel Hack Tuke (all vari-

ously associated with the Bethlem Royal Hospital), and James Adam (superintendent of the Crichton Royal Institution in Dumfries and, later, West Malling Place Asylum). The views of these elite practitioners should not be taken as reflecting the opinions of all alienists of this period. Their involvement in teaching and research (in most instances) may have contributed to their interest in a field of investigation that was not necessarily the focus of all — or even many — of their contemporaries, while their experiences with wealthy or educated patients may also have shaped the field of discussion.4 Nonetheless, their ideas certainly emerged from their asylum practice, and many of these alienists were also highly regarded spokesmen for the asylum system. Their efforts to define and explain the topic of 'self-mutilation' can, therefore, shed much light on general asylum approaches of the period. These, I will argue, were not solely based around concerns with heredity and a tendency to view mental disorder in somatic terms, but also incorporated social and even psychological influences.

Throughout the essay, I will use the terms 'self-injury' and 'self-mutilation' interchangeably to refer to all types of self-inflicted injury — including, but not limited to, amputation, enucleation (plucking out the eye), castration, hair-plucking, and the creation of cuts, bruises, and other skin lesions. Such reflects the nineteenth-century usage of both terms, which were very broadly defined by alienists and those around them.5

Self-Mutilation and Suicide

More recent texts within psychology, psychiatry, and, at times, the history of medicine, tend to assume a close relationship between self-inflicted injury and suicide. This might reflect the emphasis placed by contemporary clinicians on Karl Menninger's landmark study, *Man Against Himself* (1938). The psychoanalytically oriented Menninger regarded self-mutilation as an unconscious mechanism for *avoiding* suicide in the individual, by the concentration of a 'suicidal impulse' on one part of the body as a substitute for the whole. Self-inflicted injuries — including 'self-mutilation, malingering, compulsive polysurgery', and 'certain unconsciously purposive accidents' — were thus incorporated by Menninger under the banner of 'focal suicide'.6 Modern texts (including the only book-length work on self-mutilation, psychiatrist Armando Favazza's *Bodies Under Siege*) often cite Menninger as the first doctor to regard self-mutilation as a topic worthy of discussion, assuming that earlier physicians made no distinction between self-mutilation and suicidal acts.7 Thus, while suicide has received much attention in medical history, other forms of self-inflicted injury have not. For some, self-mutilation appears to be a clear-cut category, an attitude that has also prevailed in discussion of attempted suicide.8 Similarly, histories of suicide either bypass self-mutilation altogether or fail to acknowledge any distinction — lay or medical — between suicide and other forms of self-inflicted injury prior to the twentieth century, conveying the erroneous impression that none was made. For exam-

ple, while claiming to discuss the 'History of Suicide and Self Harm', a chapter of German Berrios's work on mental symptoms focuses solely on published literature on suicide.9 The few critical histories of self-mutilation — investigating the way in which ideas of self-harm have been formulated — focus on twentieth-century ideas.10

Yet late nineteenth-century alienists certainly *did* draw a distinction between self-mutilation and suicidal acts. Indeed, as early as 1844, standardized admission papers to the Bethlem Royal Hospital enquired whether a patient was 'disposed to suicide, or otherwise to self-injury', suggesting separate, albeit related, symptoms of mental disorder.11 From the late 1860s, the term 'self-mutilation' increasingly began to appear in published psychiatric papers and asylum case-books, as well as in newspaper articles declaring certain acts to be 'self-mutilation from insanity'.12 Alienists in the later nineteenth century frequently referred to the importance of distinguishing self-mutilation from suicide, although they rarely cited the reason for such distinctions.13 Sometimes, this emphasis may have been to protect the reputation of the asylum, for the public and Lunacy Commissioners alike regarded suicides in asylums as tantamount to neglect (Shepherd and Wright, pp. 175–96). In the Ipswich Asylum Annual Report for 1871, for example, the medical superintendent discussed a case in which a patient died several weeks after having torn out his eye, stating that 'the only remark I should wish to make upon this case is that I never considered it one of suicide, but simply one of self-mutilation'.14 Self-mutilation, although essentially related to suicide, might be presented quite differently: more akin to accidental injury than intentional act. Thus, in the same report from Ipswich, a list of 'accidents' included 'one patient [who] bit off the first joint of her little finger whilst in a state of epileptic delirium' (p. 274). Self-mutilation, like the term 'self-homicide', did not necessarily imply intent.15 Such a distinction between self-mutilation and suicide also served to protect the patient (and his or her family) from the legal and religious consequences of suicide and, indeed, attempted suicide, which had been newly criminalized mid-century (Anderson, p. 263).

Physiology and the Somatic Model of Self-Mutilation

However, for some commentators suicide was depicted as *less* unpleasant and more likely to be rational than self-mutilation. Although suicide went against the supposed 'natural instinct' of self-preservation, it had long been philosophically linked with rational behaviour, a connection which was increasingly emphasized with the revival of Stoicism in the later nineteenth century.16 But where did self-mutilation fit in relation to 'natural' processes, and what did its occurrence mean? In the 1930s, Menninger warned that his chapter on self-mutilation 'is not very pleasant subject matter. Our experience

with pain makes the thought of self-mutilation even more repugnant than the thought of suicide' (Menninger, p. 203). Similarly, discussion of self-mutilation in the previous century was closely connected to philosophies of pain, in particular, the influence of Jeremy Bentham's pleasure/pain model of motivation in mankind (1789), promoted in mid-nineteenth-century psychology by the work of Alexander Bain (despite rejecting other tenets of Utilitarianism, including the 'greatest happiness principle').17 Bain's emphasis on pain and pleasure as the 'two great primary manifestations of our nature' included allusions to physical experience and mental function, using the terms to apply also to misery and happiness (Bain, pp. 31–32). He has thus been well-recognized as playing an important part in the proliferation of parallels between physiological and psychological models of mental action.18 This philosophical approach to pain, in which 'a pain that did not prompt some alleviating action would be no pain', encouraged psychiatrists to emphasize the role of the absence of pain in the self-infliction of injury (Bain, p. 346). In 1875, for example, forensic psychiatrist Richard von Krafft-Ebing claimed that the 'loss of the pain-sense is of great significance in insanity', for it 'may lead to intentional self-injury, brutality in the manner of carrying out suicide […] [or] accidents'.19 Since a brutal suicide would presumably have the same result (physically, legally, and spiritually) as any more peaceful method, one might wonder why Krafft-Ebing should stress this as a particular concern. Moreover, how could absence of pain be regarded as a motivating factor in self-inflicted injury which did not have a suicidal purpose?

[2]

The construction of a model of self-mutilation based on the supposed perversion of 'natural' instincts towards pain was promulgated by Wilhelm Griesinger (1817–1868). A German neurologist and psychiatrist, Griesinger explicitly rejected traditional psychological and metaphysical classifications of mental disorder. These took into account the manner in which an insane person's speech, demeanour, or actions differed from those in normal life. Instead, Griesinger preferred a division into psychical depression, exaltation, and debility.20 This means of classification, he hoped, would assist in uncovering associated lesions in the brain and nervous system, thus furthering the medico-scientific side of psychology, rooting diagnoses in neurological research into impulse and inhibition.21 Although most psychiatrists, in Britain and Continental Europe, agreed that much investigation was needed before the biological nature of insanity could be firmly established, Griesinger further suggested that, in the absence of hard evidence of pathological change, diagnoses must be made along the 'entire collection of nervous symptoms', including anomalies of sensation and motion. He divided such irregularities into 'anomalies of sensibility' and 'disorder of the motor power', indicating a number of subcategories in each group. Rather than being a psychical symptom, Griesinger associated self-mutilation with those insanities marked by 'decreased sensi-

bility, by anaesthesia or analgesia'. He cited the example of a patient who 'in part from wantonness, and in part to compel the attendant to send for the physician, had deliberately smashed the first phalanx of his thumb with a brick. This man told me he had not suffered the least pain' (Griesinger, p. 539). Thus, for Griesinger, elevating the status of the physiological symptom meant that the direct motive for self-mutilation could be discarded: the lack of pain was the causatory factor, not the patient's desired result.

While Griesinger's physiological aetiology of insanity was not adopted outright within British psychiatry, the view that self-inflicted injury was based on a combination of the absence of sensation and the influence of an 'insane impulse' often appeared in texts published in the second half of the century. When zoologist William Carmichael McIntosh discussed the topic in a paper 'On Some of the Varieties of Morbid Impulse and Perverted Instinct' two years later, he typified the British approach, connecting a somatic neurological basis with the environmental and hereditary factors thought to influence moral and emotional insanity:

It is found that persons will occasionally castrate themselves, amputate their arms and legs by means of a passing railway train, cut, tear, and burn their bodies, and perform other impulsive acts of torture. Amongst the insane many marked cases are observed.22

If 'many' (rather than all) such acts were symptoms of insanity, this could suggest that some might not be. This issue increasingly became a topic of discussion in the last decades of the century as self-inflicted injury became commonly associated with so-called 'nervous disorders', in particular the 'cutaneous anaesthesia' commonly regarded as a major symptom of hysteria. Nonetheless, in case-studies of self-mutilation published in the Journal of Mental Science from the 1870s, the topic of sensation (and its absence) was often a major focus, used to emphasize the manner in which self-mutilation contravened natural laws.23

[4]

Despite the claimed objectivity of such an approach to self-inflicted injury, classification relied on doctors' reports that patients themselves confirmed that they had, indeed, felt no pain. Griesinger's example is complicated by his inclusion of the other motives cited by his patient, despite having claimed such concerns to be irrelevant within his scheme. As Michael J. Clark has since recognized, new physiological approaches to mental disorder in this period frequently remained complicated by metaphysical or psychological concerns.24When looking at nineteenth-century depictions of self-mutilation, therefore, we cannot attempt to make any clear divide between physiological and psychological interpretations of behaviour. Indeed, in Britain at least, the majority of those alienists who discussed self-mutilation in the later nineteenth century

rejected rigidly somatic interpretations of illness. Savage, for example, was an outspoken critic of Henry Maudsley's 'tyranny of organization': the claim that mental illness was biologically inherited, and thus the inevitable fate of those born of 'nervous' stock.25 Theo Hyslop, meanwhile, emphatically rejected so-called 'medical materialism': the assumption that mental illness could be explained and understood through brain biology alone.26 The difficulties in making distinctions between the mental and physical are brought into clear relief by a closer examination of the case-books kept by these practitioners, which also indicate the complex way in which the interpretation of self-mutilation relied on interaction between doctors and patients. The examination of asylum practice alongside published texts can thus offer us greater insight into psychiatric ideas of the period: theory and practice were not necessarily one and the same.

James Adam, for example, who wrote the five-page definition of 'self-mutilation' for Daniel Hack Tuke's Dictionary of Psychological Medicine (1892), made explicit reference to examples of what he termed 'sexual self-mutilation' in his published definition (p. 1150). This category drew heavily on one particular case he had encountered at West Malling Place. On examining the case records, however, it becomes evident that this was the onlycase of self-mutilation recorded during Adam's ownership of the institution: the relatively rare occurrence of such acts as reported within asylums indicates that we cannot see classifications as simple descriptions of the occurrences of asylum life.27 Instead, definitions were created by bringing together unrelated instances reported by a variety of practitioners. Adam's patient, Captain Henry Puge Halhed, had been admitted to West Malling Place in April 1871, aged 65, over a decade before Adam purchased the institution. Halhed had previously been a Captain in the Bengal Army and, about five years before his admission to West Malling Place, had 'removed the testes & part of the scrotum [...] having the impression he must become a Eunuch to preach to a tribe in the North of India'.28Halhed's ideas were interpreted as religious and sexual delusions by both Adam and his predecessor, Thomas Lowry, although little reference was made in case-books to the somatic context referred to in published works, beyond vague allusions to 'impulse' (a term that could be interpreted both neurologically and psychologically). Indeed, the main focus lay in locating Halhed's self-mutilation within his prior experiences: anxiety over his sexual role, 'religious enthusiasm and excitement', and, in the Dictionary, the acquisition of 'Eastern languages and ways' (Adam, p. 1150). Such an explanation offered a socio-environmental account of self-inflicted injury (in addition to the influence of inherited physical traits located within the individual). Indeed, in his published definition, Adam declared that the only way to understand self-mutilation was by 'an endeavour to trace some of the motives which have prompted to the commission of the acts' (p. 1147): an idea that certainly did not fit within the physiological model proposed by

Griesinger, but shows closer links to Bain's associationist psychology.

Like Adam, late nineteenth-century Bethlem physicians George Savage and Theo Hyslop set much store in uncovering the 'motive power' of insane patients.29 Indeed, the socio-environmental model of madness that these physicians shared seems to have encouraged their interest in self-inflicted injury. But what 'motives' did these psychiatrists 'discover' in their patients? Sometimes, these did indeed fit the somatic model of self-injury offered by Griesinger. In 1889, for example, when Isabella Morant was admitted to Bethlem after attempting to cut off her hand with a carving knife (after which it had been amputated), her husband reported that she 'said she had no pain'. While in hospital, Isabella further managed to tear out one eye — something she had long threatened — and the medical officers again reported that 'there has been little or no pain', while the patient 'says she is very happy now & does not intend to do any further injury'.30 However, plenty of other patients did not fit this neat model based around sensation. In the Bethlem Hospital case notes, two other explanations put forward frequently by patients also focused on pain in very different ways: by interpreting self-injury as punishment, or as a form of treatment for pain they were currently experiencing.

While Isabella Morant indicated that her actions (both amputation and enucleation) had been required by a higher power, other patients suggested their injuries were atonement for crimes. Such concepts of punishment often did assume that injuries were painful: for example, although Frederick Humphreys's efforts to burn his arms were interpreted as punishment, the patient apparently claimed that he had trained himself to bear the pain.31This notion of self-mutilation as a form of 'endurance' was sometimes suggested to be a motive behind self-inflicted injuries in sanity as well. Other patients claimed that their injuries, while not painful in themselves, provided 'relief' from other pains they had to bear: such suggestions were almost always couched in physical, rather than mental, terms. An interesting example is self-cutting, which, unlike today, was rarely specified as a distinct form of self-mutilation, possibly due to an alternative framework of interpretation located within medical treatment: phlebotomy, or bloodletting. In 1860, Elizabeth Taylor was reported as having shown

> latterly some indications of a wish to injure herself, [...] to draw blood which she fancies would relieve her [On one occasion] [...] without any obvious cause or previously speaking of it, she rushed into a chemist's shop & asked to be cupped immediately, as the only means to relieve the distress of her head.32

The complicated dialogue here between self-injury and self-treatment is apparent. Although a practice discarded by many physicians by the mid-nineteenth century, bloodletting was still widely avail-

able as a treatment for any type of illness, making it hard to define Taylor's actions as self-mutilating.33 Thus, although her sudden unexpected need for bloodletting was regarded as unusual, it was presented as little different from a compulsion to bathe; it was the perceived lack of reason and the 'supernatural voices' heard, rather than the behaviour itself, which was seen to evidence mental illness. Some twenty years later, George Joblin also reported injuring himself to 'relieve the pressure in his head'; while as late as 1900, 56-year-old Alexander McCullock declared 'that he had bled himself with a razor, because medical men were not now allowed to bleed and this relieved his head'.34 This alternative physiological understanding of self-mutilation did not require any specific information as to whether the injuries themselves were in any way painful: even if they were, this could simply be dismissed as a side-effect of treatment.

When self-injury was declared to relieve pain, what did such an idea actually mean? Today, we tend to interpret physical pain as providing potential relief from mental suffering, but these distinctions are hard to draw in nineteenth-century cases. Elizabeth Taylor, for example, spoke of 'relief' to her head, which might have indicated the easing of physical pressure (for she complained of frequent headaches) or of unspecific mental strain. Such conflation is particularly evident in the case of one young student admitted to Bethlem in 1889, when multiple explanations appear in the casebook for the same act. A private attendant prior to hospitalization stated that Charles Hipwood had cut his face because 'he liked to see the blood that followed'. Hipwood's mother, meanwhile, claimed her son told her he cut himself because 'he wanted to see if he could feel anything'. Yet, in Bethlem, an alternative explanation was implied. Although the doctors found it hard to get anything out of their patient at all, he did tell them 'that he does not want to live & hints at something dreadful that is going to happen & at great suffering which he will have to bear'. Following this, the doctors conjectured (not deeming his injuries serious enough to be interpreted as suicidal) that 'he is apparently trying to prepare himself [for this] by inflicting pain on himself now'.35 Both of the latter two explanations emphasize the proximity of physical and mental suffering in a system of medicine which assumed a close relation between bodily and mental states. Charles had apparently told his mother that 'he had been a humbug all his life & unfit to live', that he was 'ungrateful' and 'insensible to anything', following which he cut his face in three places with a knife. Similarly, in 1892, Charlotte Nash Young was reported as having 'said that she had no feeling & cut her arms, thinks that she has no blood in her body [...] and bit herself on the wrist to see if it would bleed'.36The analogy between the biological language of nerves and circulation and the moral language of emotional propriety is apparent in both cases: 'no feeling' might refer to physical sensation or emotional state. Charles Hipwood continued to make a link between nervous and moral breakdown in his letters to Bethlem following discharge, clearly reflect-

ing the contemporary conflation between physical and emotional sensation. Such ideas remain bound up in the approaches outlined below, which, while ostensibly psychological in tone, were nonetheless rooted in the foregoing physiological debate.

Between Somatic Reasoning and Psychological Meaning

When James Adam wrote of 'sexual self-mutilation', he referred his readers to the Psychopathia Sexualis of Richard von Krafft-Ebing, first published in German in 1886 (Adam, p. 1150). But what approach would interested parties have encountered in Krafft-Ebing's work, and how did it relate to the classifications of British alienists like Adam? Acknowledging the influence of Griesinger, Krafft-Ebing readily accepted the idea that self-inflicted injury resulted primarily from the failure of asylum patients to feel physical pain. However, a generation younger, Krafft-Ebing's writings were influenced by shifting ideas in Western European thought: most obviously, a commitment to altruism, emotion, and social feeling as the primary factors in the development of civilization. These concerns increased the use of parallels between physical and emotional sensation, while emphasizing the importance of sensation in the maintenance of social order.37 It is for his work on sexual pathology that Krafft-Ebing is best remembered today, and there has been much historical interest in his writings on homosexuality in particular.38 Less attention, however, has been paid to the way in which early editions of his magnum opus, Psychopathia Sexualis, created categories of pathology based on sensation. Such included both sexual hyperaesthesia (excessive sexual feeling) and anaesthesia (absence of feeling). The latter appeared particularly threatening to late nineteenth-century civilization, for Krafft-Ebing justified his research by building on the suggestions of British alienists (specifically Henry Maudsley) that sexual feeling formed the basis for social advancement, claiming that

> sexual life is no doubt the one mighty factor in the individual and social relations of man that discloses his powers of activity, of acquiring property, of establishing a home, and of awakening altruistic sentiments toward a person of the opposite sex, toward his own issue, as well as toward the whole human race.39

When broken down, such a statement can appear mystifying to a twenty-first-century reader in some areas (what can sex have to do with acquiring property?) and exaggerated in others. Yet many of his claims are closely connected to the ideas of his contemporaries: Darwin, Spencer, and well-known evolutionary anthropologists had all viewed the development of 'sympathy' or 'altruistic sentiments' as the highest achievement of mankind.40 Maudsley and other alienists claimed that such sentiments were developed in puberty, thus assuming that the acquisition of moral feeling was closely associated with physical (sexual) development.41

So, how did Krafft-Ebing incorporate self-inflicted injury into this model? Alt-

hough the categories of 'sadism' and 'masochism' were added to the 1890 edition of Psychopathia Sexualis (and thus available to Adam in writing his 1892 definition of 'self-mutilation'), none of the case-studies referring to self-mutilation appear under these headings.42Instead, the most complete case of 'sexual self-mutilation' is incorporated into 'sexual anaesthesia'. One of Krafft-Ebing's earliest published cases concerned E., a thirty-year-old journeyman painter.43 Krafft-Ebing was called as a medical witness after E. was arrested,

while trying to cut off the scrotum of a boy he had caught in the woods. He reported that he wished to cut it off so that the world would not multiply. Often in his youth, for the same reason, he had cut into his own genitals. (p. 67)

Voicing the Malthusian idea that population growth would inevitably outstrip natural resources, E.'s concerns acted out the fears of many others, for he felt that 'it was better to castrate all children than to allow others to come into the world, and whose only fate would be to endure poverty and misery'. On Krafft-Ebing's testimony, E. was judged insane, and sent to an asylum rather than prison. This judgment meant that E.'s concerns about procreation and the poverty of his own childhood could also be dismissed as irrational. Instead, Krafft-Ebing's emphasis lay in an association between E.'s violent acts (both to himself and others), his lack of desire for 'normal' sexual intercourse, and his personality. Given the writer's strong belief in the altruistic potential of sexual activity, it is hardly surprising that he found E. 'selfish and weak-minded', 'moody, defiant, irritable' and a lover of solitude. Conclusively, Krafft-Ebing declared that 'social feelings were absolutely foreign to him' (Krafft-Ebing (1999), p. 68). Interestingly, E. did, in fact, feel physical pain: Krafft-Ebing noted that the patient's attempts at 'self-emasculation' had not been carried out because of pain. Nonetheless, this brief note was not allowed to detract from an overall correlation between the absence of physical (sexual) feeling and a lack of emotional and social feeling. Reports in British journals made similar analogies in cases of self-mutilation. When a young farmer, Isaac Brooks, was reported as having twice attempted to castrate himself in 1882, medical journals saw Brooks's 'eccentric, solitary, and reserved habits' as having led directly to self-injury: his lack of social (and thus, it was assumed, physical) feeling was viewed as having precipitated the act.44

This correlation between physical and emotional anaesthesia was also frequently made in the diagnosis of hysteria in the same period. Cutaneous anaesthesia was regarded as a common symptom of nervous illness, and doctors in hospitals for nervous diseases (such as the National Hospital at Queen Square) frequently carried out sensation tests on their patients with the use of a pin. Despite commenting on the suggestibility of hysterical subjects, these physicians seemed to see little problem in searching for anaesthesia, with the result that, according to Sydney Coupland at the Middlesex Hospital, they usually found it (Coupland, p. 644). Such an approach occurred in asylums as well as general hospitals, with the

location of physiological symptoms at times overruling the subjective experiences of the patient.

Edith Mary Ellen Blyth was admitted to Bethlem in February 1893, aged thirty. She had been considered to be suffering from hysteria for five years prior to her admission to Bethlem with a diagnosis of mania, during which time she was seen by 'over 20 doctors' for an apparent skin disease, until 'last June [she] was taken to Mr Treves who said the sores were self-inflicted and they ceased to appear soon after this'. Edith was admitted to Bethlem for the most part, it seems, due to her renewed engagement in acts of self-mutilation. Nonetheless, her case certainly did not seem to prove the oft-posited link between self-inflicted injury and anaesthesia: the 'hysterical symptoms' to which she had been subject for eleven years — 'inability to walk, to see, to speak & faints' — did not include a loss of sensitivity to pain. Indeed, Edith gave clinical assistant Dr Rivers a detailed account of her injuries, which, she reportedly said, 'were done by scraping with a pair of scissors, and rubbing in ammonia afterwards. […] The process was accompanied with considerable pain but that she felt an uncontrollable impulse to do it.' Subsequent to admission, however, Edith's sensibility was examined using a pin and it was claimed that much 'anaesthesia and hemianalgesia' was found: the patient's subjective claim that she felt pain could now be doubted — and even discarded.45

Rivers' detailed account of Edith's case is just one among many examples which indicate that the main interest for many doctors lay in the history of the injury itself (when, where, and how it was created) and the details of treatment leading to the discovery of self-infliction.46 Indeed, while the above quotation appears to indicate some interest in *why* Edith might have inflicted injuries upon herself, in the full case notes this is subsumed within a detailed account of the 'when' and 'where', and is nowhere the main focus of enquiry. The patient's claim that her self-inflicted injuries were the result of forces she could not control does not appear to have been accepted. Rather than either regarding her injuries as irrational symptoms of mental illness *or* exploring any deeper psychological meaning in the infliction of her wounds, much of Edith's treatment appears to have been explicitly moral (in both senses of the word). Both Rivers and his colleague Maurice Craig repeatedly tried to impress upon the patient that her actions were 'wrong', puzzled by her insistence that she had no intention of deceiving anybody and never realised for one moment she was doing anything she ought not to do and thought the remedies prescribed for her would cure her. When shewn the folly of this she said she 'did not put two and two together.' She recognises that it is a disgraceful thing to have such injuries but thinks she has done nothing wrong because she could not help it.47

The implication here is that, although Edith might have been certified insane (and thus irrational), she could, nonetheless, control her behaviour. Indeed, further notes regularly complained about the patient's troublesome behaviour in the asylum, where she consistently bit, scratched, and attempted to set fire to herself, and she was discharged uncured after less than eight months (the rules of Bethlem usually allowed patients at least a year of treatment). Although the attitude was perhaps kinder than that of Edith's mother who 'for 3 years […] has suspected that […] [Edith] made the sores on her legs worse & has not been sympathetic in any way', the understanding of Edith's self-mutilation was located within the widespread medical and popular view of the hysterical patient as manipulative and attention-seeking.48

The connection between self-inflicted injury, absence of pain, and 'selfish' behaviour was drawn most explicitly in William James's well-known paper on emotion.49 James's theory of emotions, published in *Mind* in 1884 and incorporated into his well-known textbook, *Principles of Psychology* (1890),has influenced much twentieth-century work on the topic.50In what is often regarded as an unusually materialistic stance, James suggested that, rather than accompanyingemotional ideas, physiological change in the body preceded — and even *caused* — emotional feeling. Despite much disagreement at the time, and the existence of a number of opposing theories, James's view has dominated much twentieth-century Anglo-American thought on emotions and affect, in particular Robert Plutchik's well-known 'basic theory of emotions', which suggested an evolutionary 'fight or flight' component to human feeling.51 Drawing a parallel between normal and abnormal psychology, James suggested that his theory might be supported by observing the behaviour of individuals who experienced no physical sensation. Indeed, it would prove a 'strong presumption' in favour of his hypothesis if a 'case of complete internal and external corporeal anaesthesia, without motor alteration or alteration of intelligence except emotional apathy' were found. The obvious starting point here, for James, was the asylum, and he referred to several articles by contemporary German alienists as a hesitant test of his theory, before calling for 'asylum-physicians and nervous specialists [to] begin methodically to study the relation between anaesthesia and emotional apathy' (James, pp. 203–04). Self-inflicted injury would, no doubt, have seemed an obvious starting point.

Conclusion

It does not appear that James's suggestions for further study were taken up to any extent, at least in British asylums. Nonetheless, they formed part of a system of medical (and lay) understanding which claimed a close relation between physical and psychological feeling: with insanity often characterized as showing an absence of both. This, as I have argued, was one of the important areas in which self-mutilation was distinguished from suicide, although the two topics certainly remained related. Self-inflicted injury was initially suggested by Griesinger and other physiological psychia-

trists to be an objective symptom of insanity due to its assumed relation to absence of pain (a model of feeling not necessarily posited in cases perceived to be suicidal, which were more often understood in relation to a rational model of suicide as an *escape* from pain). Nonetheless, such ideas were complicated within British asylum practice by the emphasis on self-mutilation as a response to both an absence and an *excess* of pain. As the use of asylum case-books in conjunction with published texts has indicated, the reporting of cases of self-mutilation cannot be seen simply as a description of the realities of asylum life. Instead, reports of self-mutilation were constructed by patients and doctors in a multi-layered process, drawing on the prior experiences reported by the patient, medical views of the role of sensation and its absence in mental disorder, and the cultural significance of emotional and moral feeling. This socio-environmental approach to self-mutilation is apparent in the approaches of physicians towards other symptoms of mental illness, such as the 'sexual anaesthesia' of Richard von Krafft-Ebing. It did not, moreover, preclude censure of the patient — as in the case of Edith Blyth — suggesting that absence of feeling was deemed to be located in the individual's biology or character, as well as in their socio-environmental context. Nonetheless, the two approaches were mutually constitutive: situating the onset of the individual's disorder in social concerns *as well as* regarding the insane individual as a potential danger to social order. For some writers in the late nineteenth century, as I have shown elsewhere, self-mutilation became synonymous with 'selfishness': an inability to respond to the 'altruistic sentiments' regarded as vital for the progress of civilization.52 This did not, however, rule out the simultaneous interpretation of self-inflicted injury as a response to emotional (societally created) pain. In either instance, however, it is impossible to draw a sharp distinction between physical and emotional pain, both within the topic of self-mutilation and in wider psychiatric discourse, opening up broader questions about the relationship of body to mind in psychological medicine in the late nineteenth century.

1. Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), p. 11.

2.See Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* (Baltimore: Johns Hopkins University Press, 1996), pp. 243–53; E. David Klonsky, 'The Functions of Deliberate Self-Injury: A Review of the Evidence', *Clinical Psychology Review*, 27 (2007), 226–39.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

3. Scarry, in contrast, assumes that the relief of one pain by another must be the substitution of physical for psychological pain (pp. 33–34). See also Roselyne Rey, *History of Pain* (Paris: La Découverte, 1993), pp. 105–07.

4. *All* of the British asylum physicians who wrote on self-mutilation treated wealthy or middle-class patients (Bethlem, although previously having accepted 'pauper' patients, catered solely for the 'educated classes' by this period). The class implications implicit within many definitions of self-mutilation (including an alternative interpretation of self-inflicted injuries in the working classes as 'malingering') is beyond the scope of this discussion, but will be dealt with in the thesis from which this essay originates.

5. See James Adam, 'Self-Mutilation', in *A Dictionary of Psychological Medicine*, ed. by Daniel Hack Tuke (London: Churchill, 1892), pp. 1147–52; P. Maury Deas, 'The Uses and Limitations of Mechanical Restraint as a Means of Treatment of the Insane', *Journal of Mental Science*, 42 (1896), 102–13.

6. Karl A. Menninger, *Man Against Himself* (San Diego: Harcourt Brace Jovanovich, 1985), pp. 201–308.

7. Favazza, p. 232. See also Margaret McAllister, 'Multiple Meanings of Self Harm: A Critical Review', *International Journal of Mental Health Nursing*, 12 (2003), 177–85; Barent W. Walsh and Paul M. Rosen, *Self-Mutilation: Theory, Research, and Treatment* (New York: Guilford Press, 1988); P. M. Rosen and B. W. Walsh, 'Patterns of Contagion in Self-Mutilation Epidemics', *American Journal of Psychiatry*, 146 (1989), 656–58; B. Parry-Jones and W. L. Parry-Jones, 'Self-Mutilation in Four Historical Cases of Bulimia', *British Journal of Psychiatry*, 163 (1993), 394–402.

8. A forthcoming article by Åsa Jansson makes an important step towards filling this gap in scholarship, highlighting the way in which historians have assumed the existence of a 'real' number of suicidal asylum patients, thus failing to explore how the idea of a person *being* suicidal emerged. Åsa Jansson, 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Medicine', *Journal of Social History*, 46 (2013, forthcoming). For previous work, see, in particular, Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon Press, 1987), pp. 263–417; Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, 46 (2002), 175–96.

9. G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1995), pp. 443–54.

10. Barbara J. Brickman, '"Delicate" Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse', *Body & Society*, 10 (2004), 87–111; C. Millard, 'Self-Mutilation and a Psychiatric Syndrome: Emergence, Exclusions & Contexts (1967–1976)' (unpublished master's thesis, University of York, 2007).

11. This question was not altered until Bethlem belatedly became incorporated under the Lunacy Acts in 1853, and the reception order required under the 1845 Act (which referred only to suicide) was adopted.

12. 'The Case of the Farmer Brooks', *The Lancet*, 119 (1882), 73. Newspapers repeated this quotation verbatim. See, for example, F. W. Warrington, 'The Strange Confession in Staffordshire', *The Times*, 13 January 1882, p. 10.For more background on the emergence of the term, and the types of behaviour to which it referred, see Sarah Chaney, 'Self-Control, Selfishness and Mutilation: How "Medical" is Self-Injury Anyway?', *Medical History*, 55 (2011), 375–83; Sarah Chaney, '"A hideous torture on himself": Madness and Self-Mutilation in Victorian Literature', *Journal of Medical Humanities*, 32 (2011), 279–89.

13. T. N. Brushfield, 'On Medical Certificates of Insanity', *The Lancet*, 115 (1880), 711–13; Henry Rayner, 'Melancholia and Hypochondriasis', in *A System of Medicine*, ed. by T. Clifford Albutt (London: Macmillan, 1899), pp. 361–81; Maury Deas, pp. 102–13.

14. 'Asylum Reports for 1871', *Journal of Mental Science*, 18 (1872), 262–76 (p. 274).

15. For this distinction between suicide and self-homicide, see Rayner, p. 369.

16. J. A. Mangan and James Walvin, *Manliness and Morality: Middle-Class Masculinity in Britain and America, 1800–1940* (Manchester: Manchester University Press, 1987).

17. Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, ed. by Benjamin Giles King (London: Pickering and Wilson, 1823), p. 1; Alexander Bain, *The Emotions and the Will* (London: Parker, 1859), esp. pp. 31–35 and pp. 336–50.

18.

Lorraine J. Daston, 'The Theory of Will versus the Science of Mind', in *The Problematic Science: Psychology in Nineteenth-Century Thought*, ed. by William Ray Woodward and Mitchell G. Ash (New York: Praeger, 1982), pp. 88–115; Robert M. Young, *Mind, Brain and Adaptation in the Nineteenth Century* (Oxford: Clarendon Press, 1970), pp. 101–33.

19. R. von Krafft-Ebing, *Text-Book of Insanity: Based on Clinical Observations for Practitioners and Students of Medicine* (Philadelphia: Davis, 1904), p. 120.

20. W. Griesinger, 'German Psychiatrie; An Introductory Lecture, Read at the Opening of the Psychiatric Clinique, in Zürich', *Journal of Mental Science*, 9 (1864), 531–47 (p. 533).

21. For a history of the latter idea see Roger Smith, *Inhibition: History and Meaning in the Sciences of Mind and Brain* (London: Free Association Books, 1992).

22. W. C. McIntosh, 'On some of the Varieties of Morbid Impulse and Perverted Instinct', *Journal of Mental Science*, 11 (1866), 512–33 (p. 528).

23. James C. Howden, 'Notes of a Case — Mania followed by Hyperaesthesia and Osteomalacia. Singular Family Tendency to Excessive Constipation and Self-Mutilation', *Journal of Mental Science*, 28 (1882), 49–53; Sydney Coupland, 'Hysterical Anaesthesia', *The Lancet*, 110 (1877), 644–45.

24. Michael J. Clark, '"The data of alienism": Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850–c.1900' (unpublished doctoral thesis, University of Oxford, 1983).

25.George Savage, 'The Influence of Surroundings on the Production of Insanity', *Journal of Mental Science*, 37 (1891), 529–35 (p. 529); George Savage, 'Henry Maudsley', *Journal of Mental Science*, 64 (1918), 117–29 (p. 118).

26.Theo Hyslop, *Mental Physiology: Especially in its Relations to Mental Disorders* (London: Churchill, 1895).

27. A similar point is made by Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (Charlottesville: University Press of Virginia, 1998).

28. Kent County Archives (KCA), *West Malling Place Case Histories (Visitors)*, 1877–1893, p. 200 (Ch84 / Mc3).

29.George Savage, 'Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 32 (1886), 313–31.

30. Bethlem Royal Hospital Archives (BRHA), *Female Patient Casebook 1889*, p. 76 (CB/137).

31. BRHA, *Male Patient Casebook 1897*, p. 21 (CB/156).

32. BRHA, *Female Patient Casebook 1860*, p. 39 (CB/77).

33. See the continuing recommendation of bloodletting by some physicians into the twentieth century in G. B. Risse, 'Renaissance of Bloodletting — Chapter in Modern Therapeutics', *Journal of the History of Medicine and Allied Sciences*, 34 (1979), 3–22.

34. BRHA, *Male Patient Casebook 1880*, p. 70 (CB/116); BRHA, *Male Patient Casebook 1900*, p. 50 (CB/163).

35. BRHA, *Male Patient Casebook 1889*, p. 18 (CB/136).

36. BRHA, *Female Patient Casebook 1892*, p. 113 (CB/144).

37. For background on 'altruism', see Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain* (Oxford: Oxford University Press, 2008); Stefan Collini, *Public Moralists: Political Thought and Intellectual Life in Britain 1850–1930* (Oxford: Clarendon Press, 1991).

38. Vern L. Bullough, *Science in the Bedroom: A History of Sex Research* (New York: Basic Books, 1994); Harry Oosterhuis, *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Indentity* (Chicago: University of Chicago Press, 2000);

Michel Foucault, *The History of Sexuality: The Will to Knowledge* (London: Penguin, 1998).

39. R. von Krafft-Ebing, *Psychopathia Sexualis* (London: Rebman, 1899), p. 1.

40. Charles Darwin, *The Descent of Man* (Amherst: Prometheus Books, 1998), p. 144; Herbert Spencer, 'The Comparative Psychology of Man', *Mind*, 1 (1876), 7–20; Edward B. Tylor, 'Primitive Society (Part I)', *Contemporary Review*, 21 (1872), 701–18. For a clear indication of the way in which these ideas were incorporated into psychiatry, see Daniel Hack Tuke, 'Moral or Emotional Insanity', *Journal of Mental Science*, 31 (1885), 174–90.

41. George Savage, *Insanity and Allied Neuroses: Practical and Clinical*(London: Cassell, 1884), p. 63; Henry Maudsley, *Body and Mind: An Inquiry into their Connection and Mutual Influence, Specially in Reference to Mental Disorders* (London: Macmillan, 1873), p. 34.

42. For the changes in different editions of the German publication see Renate Irene Hauser, 'Sexuality, Neurasthenia and the Law: Richard von Krafft-Ebing (1840–1902)' (unpublished doctoral thesis, UCL, 1992). The post-1890 editions are also characterized by Hauser as increasingly psychological in tone, compared to the physiological emphasis in Krafft-Ebing's earlier work.

43. For earlier examples, see Oosterhuis, pp. 133–36. Case 10 in R. von Krafft-Ebing, *Psychopathia Sexualis* (Burbank: Bloat, 1999), pp. 67–68.

44. 'The Staffordshire Mutilation Case and Confession', *British Medical Journal*, 1 (1882), 60; F. W. Warrington, 'The Case of Isaac Brooks', *Journal of Mental Science*, 28 (1882), 69–74.

45. BRHA, *Female Patient Casebook 1893*, p. 517 (CB/146).

46. For further examples see my forthcoming PhD thesis, in particular chapter 5: Sarah Chaney, 'Self-Mutilation and Identity in Psychiatry: From Insane Impulse to Unconscious Self in British Explanations of Self-Inflicted Injury, 1864–1914' (unpublished doctoral thesis, UCL, est. 2012).

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Communications or questions concerning admission to LIU Pharmacy should be submitted to the following:

Office of Admissions
LIU Brooklyn
1 University Plaza
Brooklyn, NY 11201-5372
Phone: 718-488-1011 or 1-800-LIU-PLAN
Fax: 718-797-2399
E-mail: admissions@brooklyn.liu.edu
Website: www.liu.edu/brooklyn/admissions
OFFICE HOURS
Monday & Thursday, 9:00 a.m. – 5:00 p.m.
Tuesday & Wednesday, 9:00 a.m. – 6:00 p.m.
Friday (during summer), 9:00 a.m. – 4:00 p.m.
Please contact the LIU Brooklyn Office of Admissions regarding receipt of your application.

PROFESSIONAL PROGRAM (PHARM.D.)
Office of Student and Professional Affairs
LIU Pharmacy
75 DeKalb Avenue, L130
Brooklyn, NY 11201-5372